

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21501

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Naomi A. Taylor</u>				2. Date of Death Month <u>July</u> Day <u>16</u> Year <u>1996</u>				3. Time of Death <u>1442</u>		
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>City</u>		
Funeral Director	5. Social Security Number <u>216-07-4864</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>79</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Aug 15 1916</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>		
	Usual Residence of Decedent				10a. State <u>Md.</u>				10b. County <u>City</u>		10c. City, Town or Location <u>Baltimore</u>
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <u>1506 Light Street</u>				10f. Zip Code <u>21230</u>		10g. Citizen of What Country? <u>USA</u>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>secretary</u>				16b. Kind of Business/Industry <u>Balto. City School</u>			
17. Father's Name (First, Middle, Last) <u>Allen S. Ellis</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Caroline L. Lucas</u>							
19a. Informant's Name/Relationship (Type, Print) <u>Carolyn J. Colwell Daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>415 5th Ave. Baltimore, Md. 21225</u>							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Loudon Park Cemetery</u>				Date <u>7/19/96</u>		20c. Location - City or Town, State <u>Baltimore, Md.</u>	
21. Signature of Funeral Service Licensee <u>Daniel A. Taylor</u>				22. Name and Address of Facility <u>McCully Funeral Home</u> <u>130 E. Fort Ave. Baltimore, Md. 21230</u>							
23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				e. <u>Myocardial Infarction</u> Due to (or as a consequence of):  b. <u>Cerebral hemorrhage</u> Due to (or as a consequence of):  c. <u>Right parietal-occipital infarction</u> Due to (or as a consequence of):  d.				Approximate Interval Between Onset and Death <u>5 days</u> <u>1 wk</u> <u>1 wk</u>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>Peter A. Liao MD</u>				29c. License number <u>P09792</u>		29d. Date signed (Month, Day, Year) <u>July 16 1996</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>P. Liao MD 22 S. Greene St</u>				31. Date filed (Month, Day, Year) <u>JUL 22 1996</u>				32. Registrar's Signature <u>William R. Riddell</u>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96-1624-041

AM

UNK. 96-0

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State of Maryland / Department of Health and Mental Hygiene

96 21502

Items: 1, 23 part I, 28d per MEO G-752 10/16/97 Certificate of Death reb

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

~~Unknown~~ 96-59 JOEL A. ANDERSON

2. Date of Death

Month Day Year  
MARCH 23, 1996

3. Time of Death

1:26 p.m.

4a. Facility Name (If not institution, give street and number)

1054 LEWISTOWN RD.

4b. City, Town, or Location of Death

Lewistown

4c. County of Death

TALBOT

Funeral  
Director

5. Social Security Number

161-58-9657

6. Sex

1X M 2 F

7. Age (In yrs. last birthday)

unknown 37 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
8/28/60

9. Birthplace (State or Foreign Country)

unknown PENN.

Usual Residence of Decedent

10e. State

N.C.

10b. County

unknown GUILFORD

10c. City, Town or Location

unknown HEARNERSVILLE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

unknown MEADOW BROOK, M.H.P LOT #23

10f. Zip Code

unknown 27284

10g. Citizen of What Country?

unknown USA

11. Marital Status

1 Unknown 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 Yes 2 No

If Yes, Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown 11th

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

unknown LABORER

16b. Kind of Business/Industry

CONSTRUCTION

unknown

17. Father's Name (First, Middle, Last)

unknown HAROLD A. D. ANDERSON

18. Mother's Name (First, Middle, Maiden Surname)

unknown VIRGINIA ALICE HESS

19a. Informant's Name/Relationship (Type, Print)

unknown HAROLD A. D. ANDERSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown 9946 GERMAN RD. NORTH EAST, PA. 16428

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) State rem.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Vansant

22. Name and Address of Facility

State Anatomy Board-655 W. Baltimore Street  
Baltimore, Maryland 21201-1559

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BLUNT INJURIES OF HEAD GUNSHOT WOUND TO HEAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

BARROL

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

FOUND 3/23/96

28b. Time of Injury

UNKNOWN M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

SUBJECT WAS SHOT

SUBJECT STRUCK ON HEAD

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

UNKNOWN

28f. Location (Street and Number or Rural Route Number, City or Town, State)

UNKNOWN

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald G. Wright MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

MARCH 24, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 22 1996

32. Registrar's Signature

Julia Davidson-Rodriguez

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 21503

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARRIE N. WALLBOTT				2. DATE OF DEATH MONTH DAY YEAR JULY 15 1996		3. TIME OF DEATH 6:15 P M	
4. SOCIAL SECURITY NUMBER 214-07-3438		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 100 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 14, 1896	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Frostburg Village Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Frostburg	
9c. COUNTY OF DEATH Allegany				10a. STATE Maryland		10b. COUNTY Allegany	
10c. CITY, TOWN OR LOCATION Frostburg				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER One Kaylor Circle	
10f. ZIP CODE 21532				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stock Clerk				16b. KIND OF BUSINESS/INDUSTRY G.C. Murphy Company			
17. FATHER'S NAME (First, Middle, Last) "unknown" Wallbott				18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown			
19a. INFORMANT'S NAME (Type/Print) William Harbel/Nephew				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 95 Ormand Street-Frostburg, Maryland 21532			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph B. Vansant				22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. CONGESTIVE HEART FAILURE							
DUE TO (OR AS A CONSEQUENCE OF):							
b. HYPERTENSION							
DUE TO (OR AS A CONSEQUENCE OF):							
c. AORTIC STENOSIS							
DUE TO (OR AS A CONSEQUENCE OF):							
Approximate interval Between Onset and Death 6 MONTH 16 YEARS 730 YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBRAL INFARCTION CORONARY HEART DISEASE							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide 8 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Chang Hyun OH, MD.				29c. LICENSE NUMBER D24951		29d. DATE SIGNED (Month, Day, Year) JULY 16, 96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHANG HYUN OH, MD. 48 TARN TERRACE, FROSTBURG, MD 21532							
31. DATE FILED (Month, Day, Year) JUL 22 1996				32. REGISTRAR'S SIGNATURE J. E. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21504

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Louise WEAVER			2. Date of Death Month Day Year July 18, 1996		3. Time of Death 4:33a.m.	
	4e. Facility Name (If not institution, give street and number) Franklin Square Hospital Center			4b. City, Town, or Location of Death Rossville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 236-22-5497		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 17, 1922
	9. Birthplace (State or Foreign Country) West Virginia						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 1 Brett Court Apt. 111			10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Garment Union		
	17. Father's Name (First, Middle, Last) James Hinkle			18. Mother's Name (First, Middle, Maiden Surname) Sarah Hinkle			
	19a. Informant's Name/Relationship (Type, Print) Marada J. Rohne (Niece)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7128 Oliver Beach Rd. Middle River, Md. 21220			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lahmansville Cemetery 7/20/1996		20c. Location - City or Town, State Lahmansville West Virginia		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Bruzdinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>Pancreatic cancer</u> Due to (or as a consequence of): b. <u>circulation</u> Due to (or as a consequence of): c. <u>Diabetes Mellitus</u> Due to (or as a consequence of): d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 			29c. License number D41650		29d. Date signed (Month, Day, Year) 7/19/96		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 404 Eastern Ave. Balt. MD. 21221							
31. Date filed (Month, Day, Year) JUL 22 1996							

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21505

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Doris L. Winkler</b>				2. Date of Death Month <b>July</b> Day <b>17</b> Year <b>1996</b>		3. Time of Death <b>1:20 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>6802 Golden Ring Road</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>212 34 3029</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 11, 1937</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>115 North Highland Ave.</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>		16b. Kind of Business/Industry <b>Cemetery</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Earl Flanary</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel Smith</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Betty S. Redding (sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 N. Cavesson Drive Smithville, New Jersey 08201</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Cemetery</b>		Date <b>July 19, 1996</b>		20c. Location - City or Town, State <b>Howard County, Md.</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bruzdinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221</b>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Breast Cancer - Metastatic</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>2 years</b>							Approximate Interval Between Onset and Death <b>2 years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D42729</b>		29d. Date signed (Month, Day, Year) <b>07/17/1996</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Van E. Lomis, 3000 Parkside Rd Baltimore, MD 21236</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 22 1996</b>		32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

item #1, filing 738, 8/23/96, cyw, per doctor  
#23a, part 1, II

State of Maryland / Department of Health and Mental Hygiene

96 21506

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) SAMANTHA DOROTHY WASHINGTON aka DORTHEA WASHINGTON  
Samantha D. Washington  
2. Date of Death Month 7 Day 19 Year 96  
3. Time of Death 18:00 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number) 2904 ECHODALE AVENUE  
4b. City, Town, or Location of Death BALTIMORE CITY  
4c. County of Death n/a

5. Social Security Number 217-22-5557  
6. Sex 1 ☐ M 2 ☒ F  
7. Age (In yrs. last birthday) 68 Yrs.  
8. Date of Birth (Month, Day, Year) MAY 11, 1928  
9. Birthplace (State or Foreign Country) MARYLAND

Usual Residence of Decedent

10a. State MD  
10b. County n/a  
10c. City, Town or Location BALTIMORE  
10d. Inside City Limits ☒ Yes 2 ☐ No

10e. Street and Number 2904 ECHODALE AVENUE  
10f. Zip Code 21214  
10g. Citizen of What Country? UNITED STATES

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 th College (1-4 or 5+) -  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC  
16b. Kind of Business/Industry in own home

17. Father's Name (First, Middle, Last) DANIEL HOWARD  
18. Mother's Name (First, Middle, Maiden Surname) LOUISA PRETTYMAN

19a. Informant's Name/Relationship (Type, Print) BRENDA WASHINGTON  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2904 ECHODALE AVENUE, BALTIMORE, MD 21214

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS MEMORIAL PARK  
20c. Location - City or Town, State ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee  
22. Name and Address of Facility WM.C. MARCHF H.-1101 E. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) Acute stroke  
Due to (or as a consequence of): HYPERTENSION  
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  
diffuse Atherosclerosis  
Due to (or as a consequence of):  
Approximate Interval Between Onset and Death 2-3 days  
24 hours  
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
Coronary Artery disease  
CONGESTIVE HEART FAILURE  
Anemia 2 to probable colon cancer

23b. Did tobacco use contribute to the causa of death? ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
29c. License number 025205  
29d. Date signed (Month, Day, Year) 7/20/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A. Riley G B M C 6701 N. Charles Street Balto. md

31. Date filed (Month, Day, Year) JUL 22 1996  
32. Registrar's Signature John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21507

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary B. TERRY-Williams

2. Date of Death

July 18 1996

Day Year

3. Time of Death

2:15 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Charles Health Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

261-56-0581

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

FEB. 22, 1925

9. Birthplace (State or Foreign Country)

CONNECTICUT

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1411 HOMESTEAD STREET

10f. Zip Code

21218

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3 rd

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

in private home

17. Father's Name (First, Middle, Last)

SAM TERRY

18. Mother's Name (First, Middle, Maiden Surname)

MAZIE MC CLARY

19a. Informant's Name/Relationship (Type, Print)

CLARENCE WILLIAMS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1411 HOMESTEAD STREET, BALTIMORE, MD 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST VA C EM. 7-23

Date

20c. Location - City or Town, State

OWINGS MILLS, MD

21. Signature of Funeral Service Licensee

Rae M. Smith

22. Name and Address of Facility

March F. H. East 21202  
1101 E. North Avenue Baltimore

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CEREBRAL

THROMBOSIS

unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

INSULIN DEPENDENT DIABETES

SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Farneem Lakhami

29c. License number

D28595

29d. Date signed (Month, Day, Year)

7/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARNEEM LAKHAM, 7220 PARK HEIGHTS AVE BALD MD

31. Date filed (Month, Day, Year)

JUL 22 1996

32. Registrar's Signature

Julia Davidson-Randall

21208

State  
Registrar

Baltimore, Maryland 21215-0020

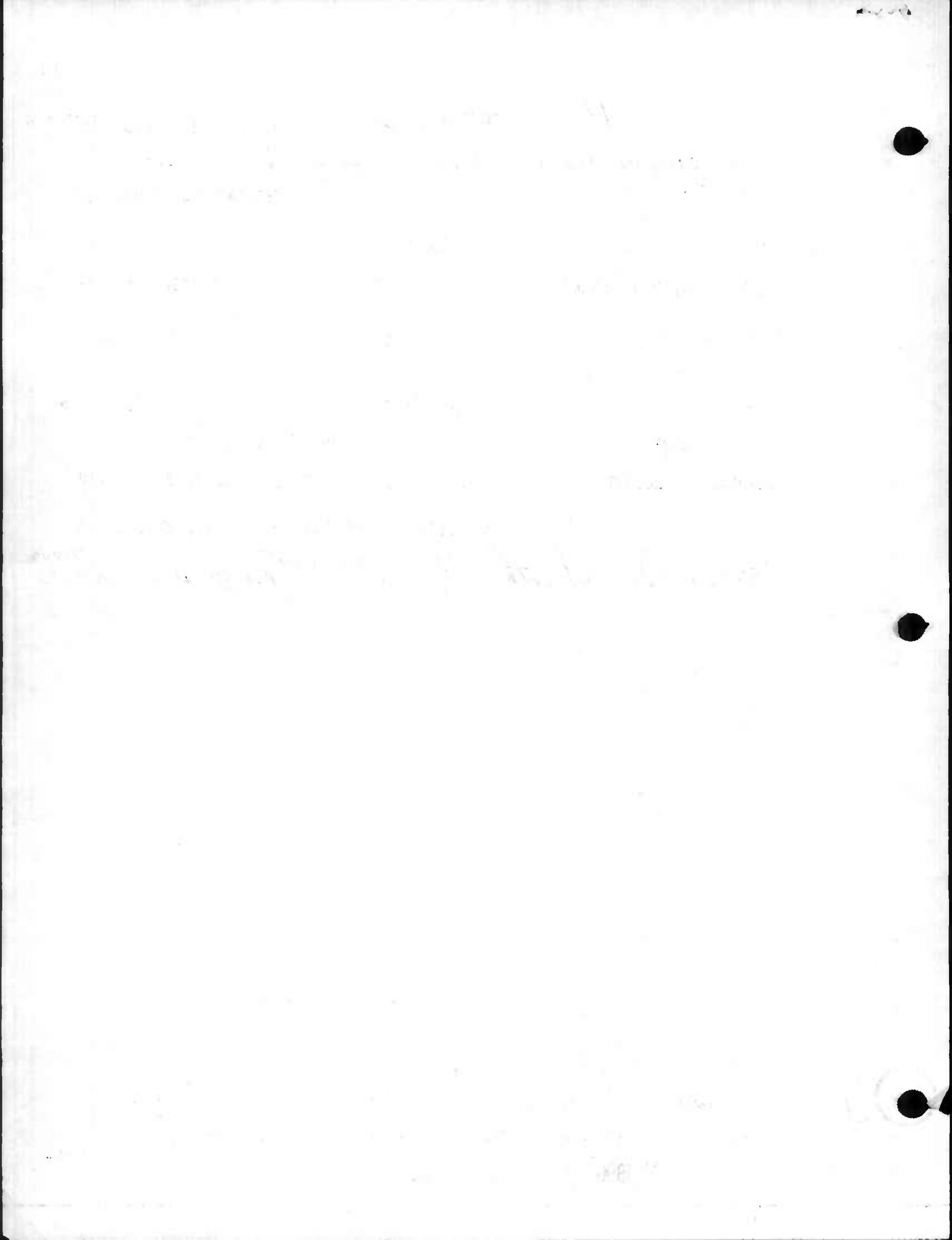
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examinerto the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21508

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HENERIETTA WHITING</b>				2. Date of Death Month <b>JULY</b> Day <b>19</b> Year <b>1996</b>		3. Time of Death <b>6:30 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>MARYLAND GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>Unknown</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>39</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 3, 1956</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2451 Francis Street</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Never Worked</b>		16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>Zack Whiting</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Ann Green</b>		19a. Informant's Name/Relationship (Type, Print) <b>Patricia Ann Whiting/sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2451 Francis Street Baltimore, MD 21217</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Date <b>07/20/96</b>		20d. Location - City or Town, State <b>Baltimore, MD</b>		21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b> <b>Dawn F. McDonald</b>	
	22. Name and Address of Facility <b>Cremation Society of Maryland, Inc.</b> <b>299 Frederick Road Baltimore, MD 21228</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. ACQUIRED IMMUNE DEFICIENCY SYNDROME</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <b>Impover</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dr. [Signature]</b>	
	29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 20, 1996</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MD [Signature] 111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>JUL 22 1996</b>	
32. Registrar's Signature <b>[Signature]</b>								

Baltimore, Maryland 21215-0020

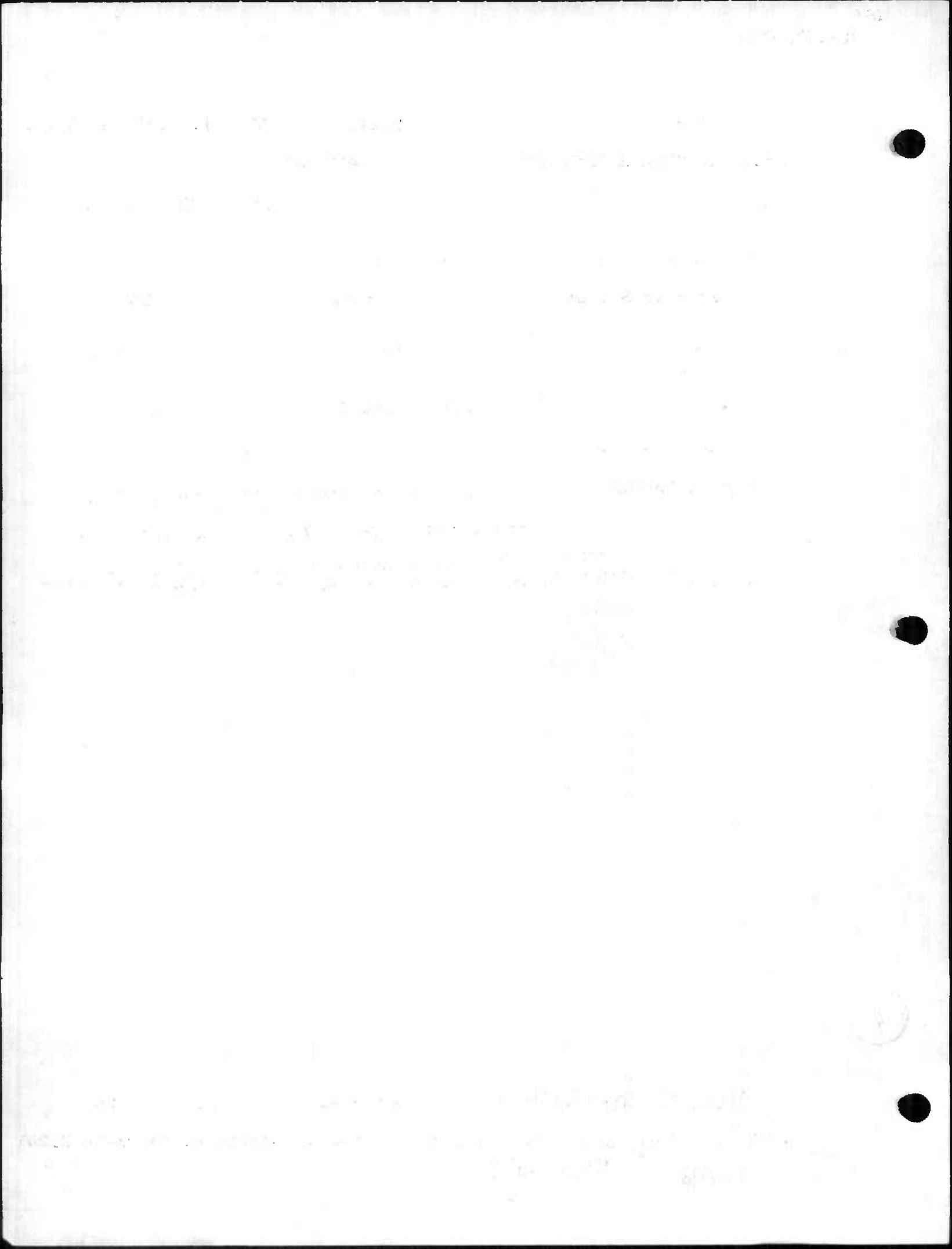
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital's Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21509

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Yvonne M. Wagner</b>				2. Date of Death Month <b>7</b> Day <b>15</b> Year <b>96</b>		3. Time of Death <b>9:25p</b>	
	4e. Facility Name (If not Institution, give street and number) <b>Hyattsville Manor</b>				4b. City, Town, or Location of Death <b>Hyattsville</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>579-76-0446</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>38</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-20-57</b>	
	Usual Residence of Decedent		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>	
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Hyattsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>6500 Riggs Road</b>				10f. Zip Code <b>20783</b>		10g. Citizen of What Country? <b>U.S..A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b>		College (1-4 or 5+) <b>unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unemployed</b>		16b. Kind of Business/Industry <b>n/a</b>	
	17. Father's Name (First, Middle, Last) <b>Herbert Emanuel Wagner, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nettie Sands</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Nettie Wagner/Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>834 7th St., N.E.-Washington, D.C. 20002</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>State rem.</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <b>Joseph B. Van Sant</b>				22. Name and Address of Facility <b>State Anatomy Board-655 W. Baltimore Street Baltimore, Maryland 21201-1559</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div> <p>a. <b>AIDS</b> Due to (or as a consequence of):</p> <p>b. <b>HEPATITIS</b> Due to (or as a consequence of):</p> <p>c. <b>CANCER</b> Due to (or as a consequence of):</p> <p>d. <b>CARDIOPULMONARY FAILURE</b> Due to (or as a consequence of):</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Robert D. Skipworth MD</b>		29c. License number <b>028906</b>		29d. Date signed (Month, Day, Year) <b>July 15, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert D. Skipworth MD, 585 MAIN STREET, LAUREL, MD, 20707</b>								
31. Date filed (Month, Day, Year) <b>JUL 22 1996</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21510

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHEN FENG WU</b>				2. Date of Death Month <b>July</b> Day <b>17</b> Year <b>96</b>		3. Time of Death <b>3:10 p.m</b>	
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-15-6810</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>20</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11/29/75</b>	9. Birthplace (State or Foreign Country) <b>CHINA</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PARKVILLE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>8430 GREENWAY ROAD #D</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>ASIAN</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STUDENT</b>		16b. Kind of Business/Industry <b>n/a</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>ZHEN C. WU</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>YING M. CHEN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>KIM WU SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8430 GREENWAY ROAD #D BALTIMORE, MD 21234</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>		20c. Location - City or Town, State <b>7/20/96 BALTIMORE, MD</b>			
	21. Signature of Funeral Service Licensee <i>Christina L. Kosczyk</i>		22. Name and Address of Facility <b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>cerebral hypoxia</b> Due to (or as a consequence of): b. <b>cerebral edema</b> Due to (or as a consequence of): c. <b>Sepsis.</b> Due to (or as a consequence of): d. <b>pneumocystis pneumonia</b> Approximate Interval Between Onset and Death <b>3 days</b> <b>4 days</b> <b>8 days</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Systemic lupus Erythematosus</b> <b>Auto Immune hemolytic anemia.</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
4	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Dr. A. Jayden MD</i>				29c. License number <b>PO 9312</b>		29d. Date signed (Month, Day, Year) <b>July 17/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Muhammed ZAYDAN, M.D. Good Samaritan Hospital.</b>							
	31. Date filed (Month, Day, Year) <b>JUL 22 1996</b>				32. Registrar's Signature <i>John T. Davidson-Randall</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21511

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KENNETH W. WALTER				2. Date of Death Month Day Year JULY 19, 1996				3. Time of Death 3:25 AM						
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death City						
Funeral Director	5. Social Security Number 016-44-2773		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5/22/53		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent														
10a. State Md.										10b. County City		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 104. W. University Parkway										10f. Zip Code 21210		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) sales				16b. Kind of Business/Industry WBFF T.V.							
17. Father's Name (First, Middle, Last) Samuel Walter, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Audrey White									
19a. Informant's Name/Relationship (Type, Print) Joe Smith / Brother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3829 Fait Ave. Baltimore, Md. 21224									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 7/20/96		20c. Location - City or Town, State Catonsville Md.							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McCully Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Causa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Sepsis Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 36 hours 3 days					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Liver Transplant Thrombocytopenia										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D43862		29d. Date signed (Month, Day, Year) July 19, 1996					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Clark Marsinger MD Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD 21287															
31. Date filed (Month, Day, Year) JUL 22 1996				32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

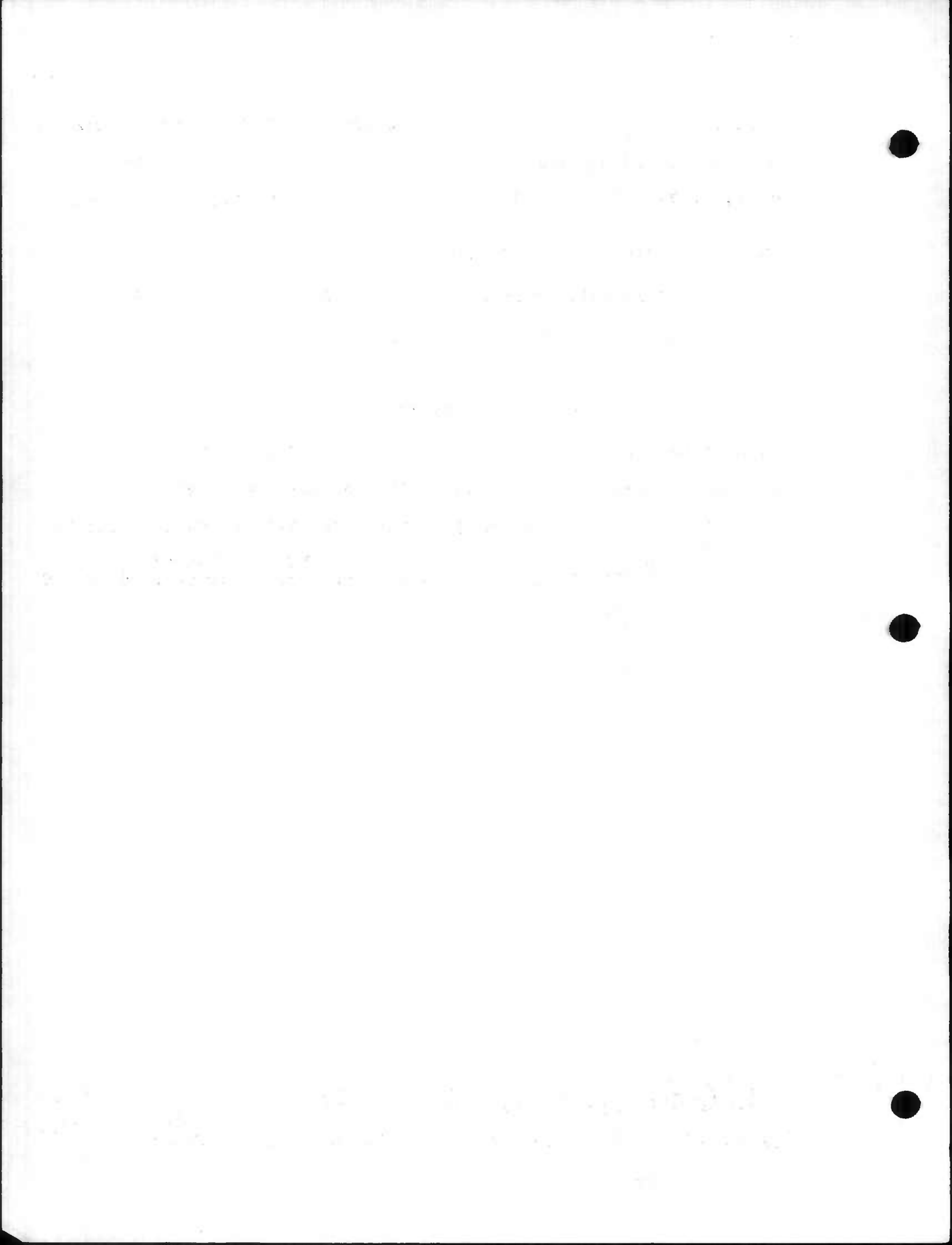
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21512

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert GRANVILLE WRAY</b>				2. Date of Death Month <b>July</b> Day <b>18</b> Year <b>1996</b>		3. Time of Death <b>3:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>				4b. City, Town, or Location of Death <b>Rossville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>213-60-2194</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F <b>XX</b>	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>8-19-1913</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>8802 Walther Blvd., Apt 2217</b>			10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U. S. A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW11</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner</b>		16b. Kind of Business/Industry <b>Wray &amp; Co.</b>			
	17. Father's Name (First, Middle, Last) <b>William P. Wray</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Dashiell</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Gwendolyn P. Wray (Wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8802 Walther Blvd., Apt 2217, Balto., Maryland 21234</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Wallace S. Brooks, Jr.</b>		22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute myocardial infarction</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>							Approximate Interval Between Onset and Death <b>2 hours</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>F. S. Chatham</b>		29c. License number <b>D16960</b>		29d. Date signed (Month, Day, Year) <b>July 18, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Frank Chatham 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>								
31. Date filed (Month, Day, Year) <b>JUL 22 1996</b>		32. Registrar's Signature <b>Julia Surfan-Rodriguez</b>						

Baltimore, Maryland 21215-0020

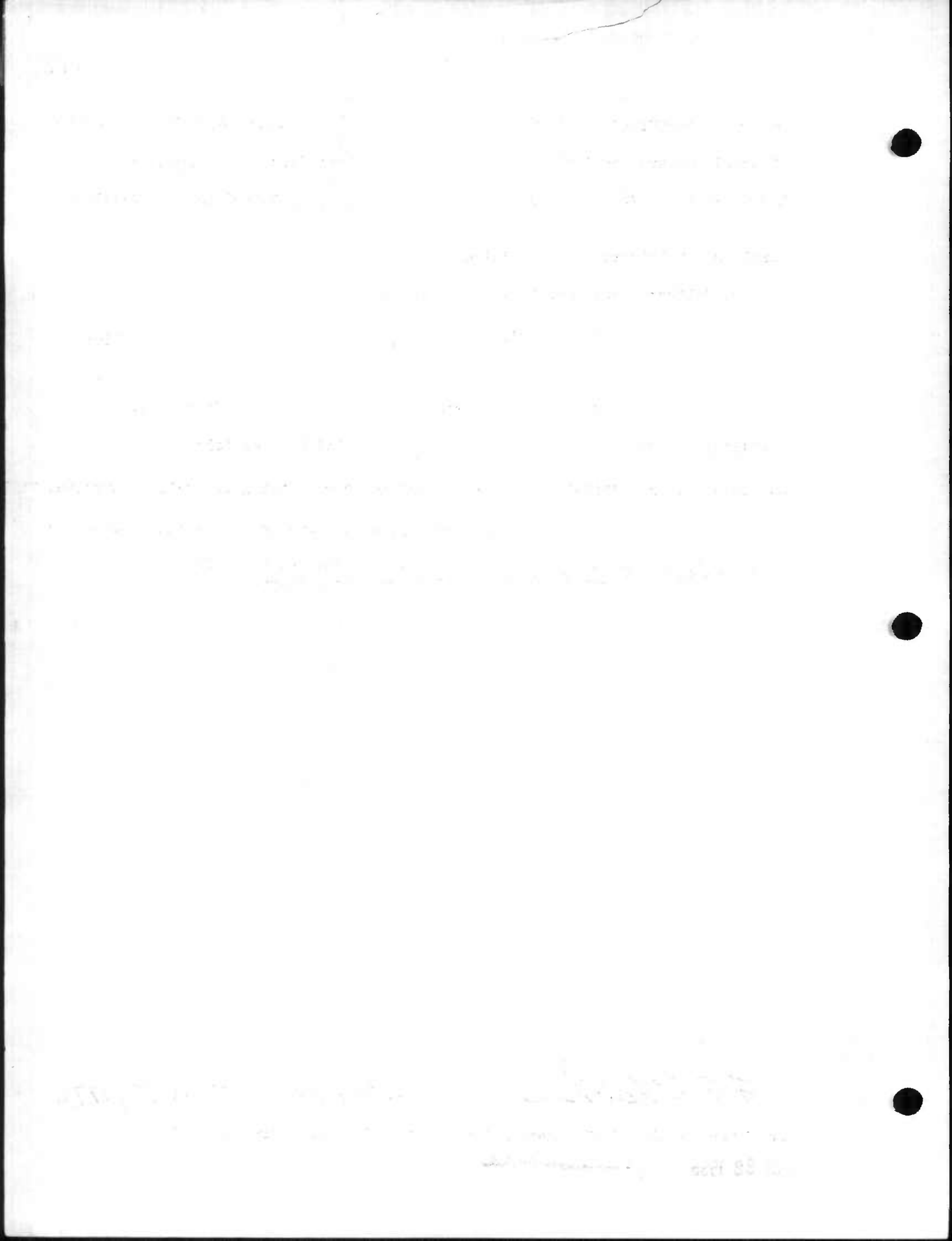
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21513

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph

YOUNG

2. Date of Death

July 22 Day 1996 Year

3. Time of Death  
4:07 am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

236-24-9616

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 15, 1923 (Month, Day, Year)

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

831 Martin Road

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 8 Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Fork Lift Operator

16b. Kind of Business/Industry

Plastics Industry

17. Father's Name (First, Middle, Last)

James Young

18. Mother's Name (First, Middle, Maiden Sumame)

Anna Mae McCombs

19a. Informant's Name/Relationship (Type, Print)

Mabel L. Young (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

831 Martin Road Essex, Md. 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens Of Faith Cemetery 7/24/1996 Baltimore Co., Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Bruzdzinski Funeral Home P.A.  
1407 Old Eastern Avenue Essex, Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Myocardial Infarction

Approximate Interval Between Onset and Death

5 hours

a. Due to (or as a consequence of):

Cardiogenic Shock

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Santha Shivananda* Resident

29c. License number

RD 01917

29d. Date signed (Month, Day, Year)

July, 22 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Savitha Shivananda M.D. 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

JUL 22 1996

32. Registrar's Signature

*Julia Madison-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21514

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN L. ALEXANDER</b>						2. Date of Death Month <b>JUNE</b> Day <b>29</b> Year <b>1996</b>		3. Time of Death <b>2:30 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>29 W. WASHINGTON STREET APT. 303</b>						4b. City, Town, or Location of Death <b>ANNAPOLIS</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>213-70-4629</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>DEC. 23 1922</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>ANNAPOLIS</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>29 W. WASHINGTON STREET APT. 303</b>				10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>US</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> Collage (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC</b>			16b. Kind of Business/Industry <b>SOME ONE ELSE HOME</b>		
	17. Father's Name (First, Middle, Last) <b>DANIEL SMITH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELEANOR SELLMAN</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>DAVID ALEXANDER (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>31 LAWRENCE AVENUE ANNAPOLIS, MD. 21403</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ANNAPOLIS MEM. GARDENS</b>		20c. Date <b>7/3/96</b>		20d. Location - City or Town, State <b>ANNAPOLIS, MD.</b>			
	21. Signature of Funeral Service Licensee <b>Harry D. Reese</b>				22. Name and Address of Facility <b>WM. REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>LUNG CANCER</b> a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	Approximate Interval Between Onset and Death <b>9 MONTHS</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Emm W. Cole MD</b>				29c. License number <b>D16354</b>		29d. Date signed (Month, Day, Year) <b>JULY 1, 1996</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>EMER W. COLE III MD 900 BESTGATE RD ANNAP MD 21401</b>										
31. Date filed (Month, Day, Year) <b>JUL 08 1996</b>		32. Registrar's Signature <b>Johie Davidson-Randall</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 21515

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GLENIS AMANN</b>				2. Date of Death Month <b>JUNE</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>1 - 35 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>473-16-3166</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>4-24-1906</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>731 Trenton Ct.</b>				10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Columnist</b>		16b. Kind of Business/Industry <b>Newspaper</b>		
	17. Father's Name (First, Middle, Last) <b>John Francis Bradish</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Charlotte Martha Pickle</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Nancy Amann AMANN</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>731 Trenton Ct. Severna Park, MD 21146</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>6/29 Catonsville, MD</b>		21. Signature of Funeral Service Licensee 		
	22. Name and Address of Facility <b>Barranco &amp; Sons Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>PNEUMONIA</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 46962</b>		29d. Date signed (Month, Day, Year) <b>JUNE 28, 1996</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. SHIRAZI, MD. HOUSE PHYSICIAN - NORTH ARUNDEL HOSPITAL. MD 21061.</b>									
31. Date filed (Month, Day, Year) <b>JUL 12 1996</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 21516

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MYRTLE ABBOTT</b>				2. Date of Death Month Day Year <b>July 5 1996</b>		3. Time of Death <b>10:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>578-07-8023</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 28, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Clinton</b>	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	10a. Street and Number <b>8606 Dangerfield Rd</b>		10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Home</b>			
	17. Father's Name (First, Middle, Last) <b>Ben Moreland</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Thomas</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Alice V. Simmons</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8606 Dangerfield Rd, Clinton, Md 20735</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery July 8, 1996 Clinton, Maryland</b>		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <b>St. S. Sitt</b>		22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735</b>					
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CARDIAC ARRHYTHMIA</b> Due to (or as a consequence of): <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>ATHEROSCLEROTIC HEART DISEASE</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CEREBROVASCULAR DISEASE</b> <b>DEMENTIA</b>		Approximate Interval Between Onset and Death <b>1 Day</b> <b>&gt; 1 Yr</b> <b>&gt; 1 Yr</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CEREBROVASCULAR DISEASE</b> <b>DEMENTIA</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier <b>RB. Sammons MD</b>		29c. License number <b>D27744</b>		29d. Date signed (Month, Day, Year) <b>7/5/96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAJ. SAMTANI MD 9131 PISCATAWAY RD CLINTON MD.</b>								
31. Date filed (Month, Day, Year) <b>JUL 09 1996</b>		32. Registrar's Signature <b>J. Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21517

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Byron H. Anson

2. Date of Death

Month Day Year  
July 4 1996

3. Time of Death

3:10pm

4a. Facility Name (If not Institution, give street and number)

Gwyn Falls Senior Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

712-09-7442

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 9 1914

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedant

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Conowingo

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

323 McCauley Rd.

10f. Zip Code

21918

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedant's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedant's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

laborer

16b. Kind of Business/Industry

auto manufacturing

17. Father's Name (First, Middle, Last)

Frank R. Anson

18. Mother's Name (First, Middle, Maiden Surname)

Ethel McCurdy

19a. Informant's Name/Relationship (Type, Print)

Mary A. Holmes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1612 Wycliffe Ave Baltimore MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt Pleasant Cemetery July 8 1996 Colora MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. T. Foard Funeral Home, P.A.

111 S Queen St Rising Sun MD 21911

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43351

29d. Date signed (Month, Day, Year)

7/5/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ikechi Fred OKWARA MD 4000 west Northern PKW Baltimore 21215

31. Date filed (Month, Day, Year)

JUL 08 1996

32. Registrar's Signature

Julia Davidson-Henderson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

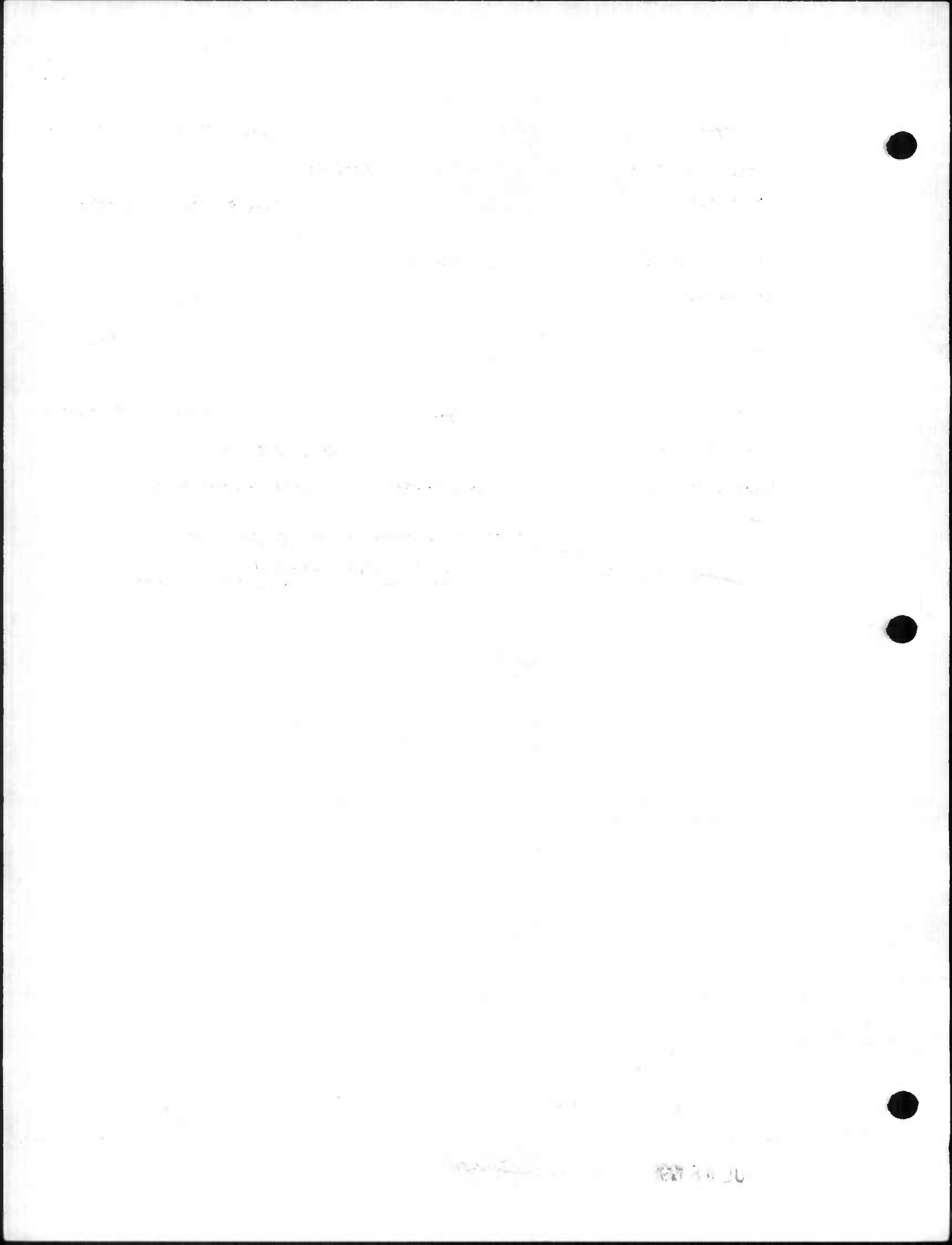
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





96 21518

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harold Andrews				2. DATE OF DEATH MONTH DAY YEAR June 27, 1996		3. TIME OF DEATH 5:45 a. m.	
4. SOCIAL SECURITY NUMBER 219-07-0910		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09/01/18	
9a. FACILITY NAME (If not institution, give street and number) Edw.W.McCready Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield		9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 201 Hall Highway				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1941-1945		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY Lumber Company			
17. FATHER'S NAME (First, Middle, Last) Alphus Andrews				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Mae Magness			
19a. INFORMANT'S NAME (Type/Print) Jack Andrews				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 Harpoon Drive, Stafford, VA 22554			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Eastern Shore Veterans 6-28 Hurlock, Maryland		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael F. Eskow				22. NAME AND ADDRESS OF FACILITY Frampton-Hawkins-Eskow Funeral Home PO Bx 43, Federalsburg, MD 21632			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Acute Cerebro-Vascular Accident					Approximate Interval Between Onset and Death 16 days
		b. Cerebral Infarct, Left					16 days
		c. Atherosclerotic Cerebro-Vascular Disease					5 yrs
		d.					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Paranoid Schizophrenia Benign Prostatic Hypertrophy							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Gregorio M. Bellosi M.D.				29c. LICENSE NUMBER D 29505		29d. DATE SIGNED (Month, Day, Year) 6-28-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, MD 21801							
31. DATE FILED (Month, Day, Year) JUL - 2 '96		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 21519

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Maxine Helen Anderson</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>4</b> YEAR <b>96</b>		3. TIME OF DEATH <b>3:15 am</b>	
4. SOCIAL SECURITY NUMBER <b>478-09-9608</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>September 26, 1917</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>William Hill Manor</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>		9c. COUNTY OF DEATH <b>Talbot</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Caroline</b>		10c. CITY, TOWN OR LOCATION <b>Denton</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>25053 Pealiquor Road</b>			
10f. ZIP CODE <b>21629</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE - American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bookkeeper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Gas &amp; Oil Company</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Philip Henry Hargreaves</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Cornelia Chapman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ronald J. Elbert</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15020 Narrows Lane, Bowie, Maryland 20716</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Pittsville Cemetery</b>		20c. DATE <b>7/8</b>		20d. LOCATION - City or Town, State <b>Pittsville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Moore Funeral Home, P.A. PO Drawer B, Denton, Maryland 21629</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Cancer metastatic to Brain</b>				Approximate Interval Between Onset and Death <b>2 months</b>	
		b. <b>Lung Cancer Suspected Primary</b>				<b>2 months</b>	
		c. _____					
		d. _____					
24. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Uterine Cancer (metastatic - 1979)</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D42005</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/5/96</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>606 Dutchman's Lane Easton MD 21601</b>							
31. DATE FILED (Month, Day, Year) <b>JUL - 8 '96</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21520

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Edward Adams				2. Date of Death Month Day Year July 6, 1996				3. Time of Death 11:00AM		
	4a. Facility Name (If not Institution, give street and number) Memorial Hospital at Easton				4b. City, Town, or Location of Death Easton				4c. County of Death Talbot		
Funeral Director	5. Social Security Number 218-01-3984		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) 01/25/15		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MD		10b. County Caroline		10c. City, Town or Location Preston				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 4429 Harmony Road Post Office Box 82				10f. Zip Code 21655		10g. Citizen of What Country? United States				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer/Construction				16b. Kind of Business/Industry Lumber Company		
	17. Father's Name (First, Middle, Last) W. Martin Adams				18. Mother's Name (First, Middle, Maiden Surname) Clara V. Friend						
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lorraine E. Adams				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4429 Harmony Rd., PO Bx 82, Preston, MD 21655						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Eastern Shore Vet.		Date 7-15		20c. Location - City or Town, State Hurlock, Maryland				
	21. Signature of Funeral Service Licensee Michael F. Eskew				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)										DAYS
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										YEARS
	Due to (or as a consequence of):										
	Due to (or as a consequence of):										
	Due to (or as a consequence of):										
	Due to (or as a consequence of):										
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEPSIS ARRHYTHMIA								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier William Bremner MD		29c. License number D26350		29d. Date signed (Month, Day, Year) 7/7/96					
30. Name and address of person who completed cause of death (item 23e) (Type, Print) William Bremner MD ST. MICHAELS MD 21663											
State Registrar	31. Date filed (Month, Day, Year) JUL - 9 '96				32. Registrar's Signature Davidson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21521

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ESTELLE MAE Bull</b>			2. Date of Death Month Day Year <b>June 17, 1996</b>			3. Time of Death <b>1306</b>			
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>			4c. County of Death <b>WICOMICO</b>			
Funeral Director	5. Social Security Number <b>229-05-6060</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR. 30, 1904</b>		9. Birthplace (State or Foreign Country) <b>VA.</b>	
	10a. State <b>VA.</b>			10b. County <b>ACCOMACK</b>			10c. City, Town or Location <b>SANFORD</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Funeral Director	10e. Street and Number <b>23256 SAXIS ROAD</b>			10f. Zip Code <b>23426</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4or 5+) <b>0</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>DOMESTIC</b>			
	17. Father's Name (First, Middle, Last) <b>LEVIN WILLIAM WHITE</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>HULDA WILKERSON</b>						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>HULDA B. WHITE (DAUGHTER)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAXIS ROAD - SANFORD, VA. 23426</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DOWNING'S CEMETERY</b>			Date <b>6-19-96</b>		20c. Location - City or Town, State <b>OAK HALL, VA.</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>THORNTON FUNERAL HOME</b> <b>P.O. BOX 264, PARKSLEY, VA. 23421</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Malignant Lymphoma</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):			Approximate Interval Between Onset and Death <b>4mo</b>						
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>020507</b>		29d. Date signed (Month, Day, Year) <b>6/18/96</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph A. Grasso 145 E CARROLL ST Salisbury MD</b>			31. Date filed (Month, Day, Year) <b>JUL 01 1996</b>						
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





96 21522

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Raymond A. Brown				2. DATE OF DEATH MONTH DAY YEAR July 6 1996		3. TIME OF DEATH 11:20 a.m.	
4. SOCIAL SECURITY NUMBER 718-18-0890		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 29, 1903	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 12608 West Old Baltimore Road		9b. CITY, TOWN OR LOCATION OF DEATH Boyd's	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland			
10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Boyd's			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 12608 West Old Baltimore Road			
10f. ZIP CODE 20841				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Brakeman		16b. KIND OF BUSINESS/INDUSTRY Railroad			
17. FATHER'S NAME (First, Middle, Last) Alexander Brown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Effie Unknown			
19a. INFORMANT'S NAME (Type/Print) Mary E. Brown				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12608 West Old Baltimore Road, Boyd's Md. 20841			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium Inc 7/8		20c. LOCATION — City or Town, State Bethesda, Maryland.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Todd D. Wynn</i>				22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth P.A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>lung cancer</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John R. Melnick MD</i>				29c. LICENSE NUMBER D19294		29d. DATE SIGNED (Month, Day, Year) July 8, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN R. MELNICK 911 RUSSELL AVE GAITHERSBURG MD 20879							
31. DATE FILED (Month, Day, Year) JUL 08 1996				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21523

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles BULIK</b>				2. Date of Death Month <b>July</b> , Day <b>5</b> , Year <b>1996</b>		3. Time of Death <b>6:20 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Northampton Manor Nursing Center</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>068-12-3683</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 12, 1923</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Middletown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>7128 Limestone Lane</b>		10f. Zip Code <b>21769</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrical Engineer</b>		16b. Kind of Business/Industry <b>Government</b>			
	17. Father's Name (First, Middle, Last) <b>Vasil BULIK</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Unknown</b>		19a. Informant's Name/Relationship (Type, Print) <b>Chuck Bulik, Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7055 East Lake Meade Blvd., Apt. 1111, Las Vegas, Nev. 89115</b>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory, July 7, 1996</b>		20c. Location - City or Town, State <b>Smithsburg, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Richard E. Gray</b> MOO255		22. Name and Address of Facility <b>Keeney and Basford P.A. Funeral Home</b> <b>106 East Church St., Frederick, Md. 21701</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>Sepsis and dehydration</b> Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>~ 2 days</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>S/P CVA &amp; aphasia</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D 26499</b>		29d. Date signed (Month, Day, Year) <b>July 6, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Ronald E. Miller, MD 4 Culwell Drive, Mt. Airy, Maryland 21771</b>		31. Date filed (Month, Day, Year) <b>JUL 08 1996</b>		32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21524

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EARL W. BROWN</b>						2. Date of Death Month <b>6</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>6:34 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>N ARUNDEL CONVAL. &amp; REHAB. CENTER</b>						4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>AA</b>	
Funeral Director	5. Social Security Number <b>214-18-0437</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 6 1904</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>ANNAPOLIS</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>5 CARVER STREET</b>						10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>US</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PAINTER</b>			16b. Kind of Business/Industry <b>SELF EMPLOYED</b>			
17. Father's Name (First, Middle, Last) <b>RICHARD W. BROWN</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>ESTELLA HENDERSON</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MARY TAYLOR (NEICE)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>48 BLOOMSBURY SQUARE ANNAPOLIS, MD. 21401</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BREWER HILL CEMETERY</b>			20c. Location - City or Town, State <b>ANNAPOLIS, MD.</b>		20d. Date <b>JULY 1, 1996</b>		
21. Signature of Funeral Service Licensee <b>Harry B. Reese</b>						22. Name and Address of Facility <b>WM. REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Dementia</b> <b>Peripheral vascular disease</b> <b>Anemia</b>  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Dementia</b> <b>Peripheral vascular disease</b> <b>Anemia</b>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>W. Delaney MD</b>						29c. License number <b>D-40521</b>		29d. Date signed (Month, Day, Year) <b>July 1, 1996</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. OCHANEY 3350 WILKENS AVENUE SUITE 302 BALTIMORE, MD 21229</b>										
31. Date filed (Month, Day, Year) <b>JUL 8 1996</b>		32. Registrar's Signature <b>John Davidson-Randall</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Amended #7 OK

96 21525

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Elizabeth L Biro</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 5 1996</b>		3. TIME OF DEATH <b>2:05P M</b>													
4. SOCIAL SECURITY NUMBER <b>383-30-0481</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov 13, 1932</b>													
8. BIRTHPLACE (State or Foreign Country) <b>Michigan</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Health Care Center/Spa Creek</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>													
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>													
10c. CITY, TOWN OR LOCATION <b>Annapolis</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1852 Carriage Drive</b>													
10f. ZIP CODE <b>21401</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>															
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>													
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>5</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Legislature Aide</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Government</b>															
17. FATHER'S NAME (First, Middle, Last) <b>Ligori Lynch</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marie Whelen</b>															
19a. INFORMANT'S NAME (Type/Print) <b>Emery J. Biro</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1852 Carriage Drive Annapolis, Maryland 21401</b>															
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft. Lincoln Crematory July 9, 1996 Brentwood, Maryland</b>		20c. LOCATION — City or Town, State		20d. DATE													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Walter E. Borky</i>				22. NAME AND ADDRESS OF FACILITY <b>John M. Taylor Funeral Home 147 Duke Of Gloucester St. Annapolis, MD 21401</b>															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> <span style="float: right;">Approximate Interval Between Onset and Death <b>2 days</b></span>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td>a. DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>Multiple Sclerosis</b></td> <td><b>&gt; 10 years</b></td> </tr> <tr> <td>b. DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> <td></td> </tr> <tr> <td>c. DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> <td></td> </tr> <tr> <td>d. DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> <td></td> </tr> </table>								a. DUE TO (OR AS A CONSEQUENCE OF):	<b>Multiple Sclerosis</b>	<b>&gt; 10 years</b>	b. DUE TO (OR AS A CONSEQUENCE OF):			c. DUE TO (OR AS A CONSEQUENCE OF):			d. DUE TO (OR AS A CONSEQUENCE OF):		
a. DUE TO (OR AS A CONSEQUENCE OF):	<b>Multiple Sclerosis</b>	<b>&gt; 10 years</b>																	
b. DUE TO (OR AS A CONSEQUENCE OF):																			
c. DUE TO (OR AS A CONSEQUENCE OF):																			
d. DUE TO (OR AS A CONSEQUENCE OF):																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO													
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO													
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)															
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Douglas C. Barnes MD</i>				29c. LICENSE NUMBER <b>D32469</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/5/96</b>													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Douglas C. Barnes MD 900 Bestgate Rd, Suite 300 Annapolis MD</b>																			
31. DATE FILED (Month, Day, Year) <b>JUL 09 1996</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>																	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21526

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Christine Carrie Brubaker</b>				2. Date of Death Month Day Year <b>July 9, 1996</b>		3. Time of Death <b>9:30 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>216-03-2196</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 11, 1917</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severna Park</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>600 McKinsey Road Apt 304</b>				10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>				
	17. Father's Name (First, Middle, Last) <b>Edwin Howard Cluverius</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lula Pole</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mr. G.M. Brubaker</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21146</b> <b>600 McKinsey Road Apt 304 Severna Pk, MD</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory 7-12-1996</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>				
	21. Signature of Funeral Service Licensee <i>James E. Barranco</i>				22. Name and Address of Facility <b>Barranco &amp; Sons Funeral Home</b> <b>495 Ritchie Hwy. Severna Park, MD 21146</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Right Intracerebral Hemorrhage</b> Due to (or as a consequence of): b. <b>Hypertension</b> Due to (or as a consequence of): c. <b>Hyperlipidemia</b> Due to (or as a consequence of): d.  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coma</b>								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number <b>D32654</b>		29d. Date signed (Month, Day, Year) <b>July 9, 1996</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>John P. Serlemiotos 1509 Ritchie Highway, Arnold, MD 21012</b>									
31. Date filed (Month, Day, Year) <b>JUL 12 1996</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21527

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Bernadette Burke				2. Date of Death Month 07 Day 07 Year 1996				3. Time of Death 2:40 am			
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 215-30-5222		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) May 16, 1908		9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 40 I. Sandstone Court				10f. Zip Code 21403		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Home					
	17. Father's Name (First, Middle, Last) James Norris				18. Mother's Name (First, Middle, Maiden Surname) Catherine Welsh							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Cathy Booker/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 I. Sandstone Ct. Annapolis, MD 21403							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Cemetery		Data 7/9/96		20c. Location - City or Town, State Davidsonville, MD					
	21. Signature of Funeral Service Licensee <i>James E. Carrano</i>				22. Name and Address of Facility Barranco & Sons Funeral Home 495 Ritchie Hwy Severna Park, MD 21146							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>circulatory failure</i> Due to (or as a consequence of): b. <i>upper gastro intestinal bleeding</i> Due to (or as a consequence of): c. <i>duodenal ulcer.</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 2 hrs. 3 days. 1 week.	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic renal failure</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
State Registrar	29b. Signature and title of certifier <i>James E. Carrano</i>				29c. License number 001861		29d. Date signed (Month, Day, Year) 7/7/96					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GONNAR ECHNET 8 GUNNABLE LN ROWAN SEVERNA PARK MD 21146											
31. Date filed (Month, Day, Year) JUL 12 1996		32. Registrar's Signature <i>John Davidson-Rodale</i>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21528

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE

AYDELOTTE BAKER

Baker

2. Date of Death  
Month Day Year

July

2

1996

3. Time of Death

1021

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

214-10-6522

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

8. Date of Birth (Month, Day, Year)

02/19/13

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Worcester

10c. City, Town or Location

Snow Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4801 Carmean Road

10f. Zip Code

21863

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

John W. Aydelotte, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marcie Boston Aydelotte

19a. Informant's Name/Relationship (Type, Print)

Carol Jean Caudell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4807 Carmean Rd., Snow Hill, Md. 21863

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bates Meth. Cemetery

Date

7/5/96

20c. Location - City or Town, State

Snow Hill, Md. 21863

21. Signature of Funeral Service Licensee

Patricia L. Dennis

22. Name and Address of Facility

Dennis Funeral Home, P.O. Box 87  
Snow Hill, Md. 21863

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Hypoxic Encephalopathy  
Due to (or as a consequence of):  
Myocardial Infarction  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Benjamin H. Meyer

29c. License number

D30743

29d. Date signed (Month, Day, Year)

7/2/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin Meyer, M.D.

403 GUNN ST.

SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

JUL 05 1996

32. Registrar's Signature

John H. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21529

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BENJAMIN L. BOLLINGER, JR.</b>				2. Date of Death Month Day Year <b>JULY 02 1996</b>		3. Time of Death <b>1725 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>UNION HOSPITAL</b>				4b. City, Town, or Location of Death <b>ELKTON</b>		4c. County of Death <b>CECIL</b>		
Funeral Director	5. Social Security Number <b>220-34-7015</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>Cecil</b>	10c. City, Town or Location <b>Elkton</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>80 Iron Hill Road</b>			10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>Automotive</b>				
	17. Father's Name (First, Middle, Last) <b>Benjamin L. Bollinger, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Joyce Rose Melvin</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Larry C. Bollinger</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>966 Augustine Herman Hwy. Elkton, Md. 21921</b>				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gilpin Manor Mem. Pk.</b>		Data <b>7/8/96</b>		20c. Location - City or Town, State <b>Elkton, Md.</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>259 E. Main Street, Gee Funeral Home Elkton, Md. 21921</b>				
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>ATHEROSCLEROTIC CORONARY VASCULAR DISEASE</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 03, 1996</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>W. D. Adams, A. Koron 111 Penn Street, Baltimore, Maryland 21201</b>									
State Registrar		31. Date filed (Month, Day, Year) <b>JUL 05 1996</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





BOLTON, GLA0Y5  
7-289 -93 -97

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21530

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys Jeanette BOLTON				2. Date of Death Month Day Year July 6, 1996		3. Time of Death 6:00 AM			
	4a. Facility Name (If not institution, give street and number) 17127 Bakersville Rd.				4b. City, Town, or Location of Death Boonsboro		4c. County of Death WASHINGTON			
Funeral Director	5. Social Security Number 214-42-6327		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 18, 1946	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Washington		10c. City, Town or Location Boonsboro			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 17127 Bakersville Rd.				10f. Zip Code 21713		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Specialist			16b. Kind of Business/Industry U.S. Government				
	17. Father's Name (First, Middle, Last) Otis Winfield Watkins				18. Mother's Name (First, Middle, Maiden Surname) Marjorie Elizabeth Jolley					
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) H. Wayne Bolton				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17127 Bakersville Rd. Boonsboro, MD 21713					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion UM Church Cem.		Data July 10, 1996		20c. Location - City or Town, State Myersville, MD 21773			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility RICKETTS FUNERAL HOME P.O. Box # 136 Myersville, MD 21773					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic Coronary Vascular Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Unknown	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Seizure Disorder</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier <u>James M. Stanley MD</u>				29c. License number M7542		29d. Date signed (Month, Day, Year) July 7, 1996			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLFE ST BALTIMORE, MD 21287									
31. Date filed (Month, Day, Year) JUL 08 1996		32. Registrar's Signature <u>John H. ...</u>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21531

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elmer Percy BACHTELL, Jr.

2. Date of Death

Month Day Year  
July 7, 1996

3. Time of Death

17:21

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

705-14-0217

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 7 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13133 Fountain Head Road

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates

1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Electric Company

17. Father's Name (First, Middle, Last)

Elmer Percy Bachtell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Eleanor Nicodemus

19a. Informant's Name/Relationship (Type, Print)

Norma S. Bachtell / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13133 Fountain Head Road Hagerstown, Md. 21742

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hagerstown Crematory

Date

07-09

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

James L. Spicer

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

years

c. Disease

Due to (or as a consequence of):

d. Coronary Artery Disease

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gangrene, right foot

Diabetes mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D1812-7

29d. Date signed (Month, Day, Year)

7/7/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. Su M.D. 370 Mill St. Hagerstown, Md. 21740

31. Date filed (Month, Day, Year)

JUL 09 1996

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


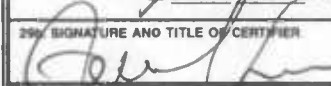
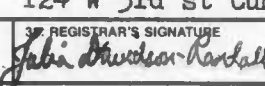
Division of Vital Records, P.O. Box 68760,



96 21532

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Kathleen Mae Brant</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 7 1996</b>		3. TIME OF DEATH <b>12:35PM</b> M	
4. SOCIAL SECURITY NUMBER <b>213-22-3130</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 14 1908</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1819 Fredrick Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1819 Frederick Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Cafeteria</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Cochran</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florence (nmn)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eugene L. Brant</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1819 Frederick Street; Cumberland, MD 21502</b>			
20a. MANNER OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Memorial Park 07/09</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pulmonary embolism</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Post-operative resection transitional cell carcinoma of the bladder</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>sudden</b> <b>11 days</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Dpty Med ex</b>				29c. LICENSE NUMBER <b>D 09157</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 7 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul Snow, M.D. 124 w 3rd st Cumb Md 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 09 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1.55

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21533

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES JAMES BUCKHOLTZ</b>				2. Date of Death Month <b>JULY</b> Day <b>08</b> Year <b>1996</b>		3. Time of Death <b>23:42</b>										
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>										
Funeral Director	5. Social Security Number <b>214-30-9754</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 17, 1930</b>										
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Lonaconing</b>										
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>18 Dudley Terrace</b>		10f. Zip Code <b>21539</b>		10g. Citizen of What Country? <b>USA</b>										
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>paper winder</b>		16b. Kind of Business/Industry <b>pulp &amp; paper</b>												
	17. Father's Name (First, Middle, Last) <b>Charles Buckholtz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Williams</b>												
	19a. Informant's Name/Relationship (Type, Print) <b>Norma Buckholtz</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18 Dudley Terrace, Lonaconing, Md. 21539</b>												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rocky Gap U.A. cemetery</b>		20c. Location - City or Town, State <b>212-96 Cumberland, Md.</b>												
	21. Signature of Funeral Service Licensee <b>James E. McKenzie</b>				22. Name and Address of Facility <b>Eichhorn-McKenzie Funeral Home - 8 East Main St. Lonaconing, Md. 21539</b>												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>e. <b>HEPATIC COMA</b> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <b>4 Hrs</b></td> </tr> <tr> <td>b. <b>Pyelonephritis &amp; septicemia</b> Due to (or as a consequence of):</td> <td><b>14 days</b></td> </tr> <tr> <td>c. <b>METASTATIC LIVER DISEASE</b> Due to (or as a consequence of):</td> <td><b>3 months</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <b>HEPATIC COMA</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>4 Hrs</b>	b. <b>Pyelonephritis &amp; septicemia</b> Due to (or as a consequence of):	<b>14 days</b>	c. <b>METASTATIC LIVER DISEASE</b> Due to (or as a consequence of):	<b>3 months</b>	d.	
	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <b>HEPATIC COMA</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>4 Hrs</b>														
b. <b>Pyelonephritis &amp; septicemia</b> Due to (or as a consequence of):		<b>14 days</b>															
c. <b>METASTATIC LIVER DISEASE</b> Due to (or as a consequence of):		<b>3 months</b>															
d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred															
28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>28334-D</b>		29d. Date signed (Month, Day, Year) <b>JULY 9th, 1996</b>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D. SHAM, M.D. 1205 JOHNSON HTS. APT BLDG. CUMBERLAND, MD 21031</b>																	
31. Date filed (Month, Day, Year) <b>JUL 10 1996</b>		32. Registrar's Signature <b>[Signature]</b>															

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21534

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY CATHERINE BOOTH</b>				2. Date of Death Month Day Year <b>JULY 8, 1996</b>		3. Time of Death <b>1959</b>											
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>											
Funeral Director	5. Social Security Number <b>214 07 6349</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 23, 1917</b>											
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>																	
Usual Residence of Decedent																		
10a. State <b>MARYLAND</b>		10b. County <b>ALLEGANY</b>		10c. City, Town or Location <b>FROSTBURG</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number <b>15510 COON CLUB ROAD, SW</b>				10f. Zip Code <b>21532</b>		10g. Citizen of What Country? <b>U.S.</b>												
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>			16b. Kind of Business/Industry <b>OWN HOME</b>											
17. Father's Name (First, Middle, Last) <b>JOHN P. GRACIE</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>FRANCES HENLINE</b>													
19a. Informant's Name/Relationship (Type, Print) <b>WILSON BOOTH / SON</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. BOX 97, ECKHART, MD 21528</b>													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ROCKY GAP VETERANS CEM.</b>		Date <b>7/11/96</b>		20c. Location - City or Town, State <b>CUMBERLAND, MD 21502</b>											
21. Signature of Funeral Service Licensee <i>Margaret M. Sowers</i>					22. Name and Address of Facility <b>SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532</b>													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>ACUTE MYOCARDIAL INFARCTION</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>&lt; ONE HOUR</b></td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>ACUTE MYOCARDIAL INFARCTION</b>	Approximate Interval Between Onset and Death <b>&lt; ONE HOUR</b>	b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>ACUTE MYOCARDIAL INFARCTION</b>	Approximate Interval Between Onset and Death <b>&lt; ONE HOUR</b>															
	b.	Due to (or as a consequence of):																
	c.	Due to (or as a consequence of):																
	d.	Due to (or as a consequence of):																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RESPIRATOR FAILURE.</b> <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown												
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No											
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
29b. Signature and title of certifier <i>Chang Hyun Oh, M.D.</i>					29c. License number <b>D24951</b>		29d. Date signed (Month, Day, Year) <b>JULY 08, 1996</b>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Chang Hyun Oh, M.D., 48 Tarn Terrace, Frostburg, MD 21532</b>																		
31. Date filed (Month, Day, Year) <b>JUL 11 1996</b>			32. Registrar's Signature <i>John Anderson-Randall</i>															

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505-555-5555.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21535

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM G. CARDWELL</b>				2. Date of Death Month <b>JUNE</b> Day <b>25</b> Year <b>1996</b>		3. Time of Death <b>8:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SALISBURY CENTER: GENESIS ELDERCARE</b>				4b. City, Town, or Location of Death <b>SALISBURY, MD.</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>171-10-5516</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 25, 1918</b>	
	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		10a. State <b>MARYLAND</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>BISHOPVILLE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>13339 HATCHERY ROAD</b>		10f. Zip Code <b>21813</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COST ENGINEER</b>		16b. Kind of Business/Industry <b>PETROLEUM</b>			
	17. Father's Name (First, Middle, Last) <b>ROBERT CARDWELL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY MIHLHOUSE</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>JANE H. CARDWELL / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13339 HATCHERY ROAD, BISHOPVILLE, MARYLAND 21813</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		20c. Date <b>6/26/96</b>		20d. Location - City or Town, State <b>SALISBURY, MARYLAND</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Renal Failure</b> Due to (or as a consequence of): <b>b. Advanced Atherosclerosis</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>  Approximate Interval Between Onset and Death <b>&lt; 1 year</b>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ischemic Cardiomyopathy</b> <b>Peripheral Vase Disease, Sp Leg Arterial</b> <b>Circumferential Ischemia / Diabetes</b>							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 		29c. License number <b>D-39813</b>		29d. Date signed (Month, Day, Year) <b>6/26/96</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>								
31. Date filed (Month, Day, Year) <b>JUN 28 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 21536

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Anthony Celia</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>01</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>8:03 P</b>	
4. SOCIAL SECURITY NUMBER <b>577-16-3003</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 4, 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Phil. Pa.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Villa Rosa Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Mitchville</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Riverdale</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>6328 Patterson Street</b>	
10f. ZIP CODE <b>20737</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Auto Mechanic</b>				16b. KIND OF BUSINESS/INDUSTRY <b>D.C. Government</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Antonio Celia</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marianna Paravati</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John Celia</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5407 Auth Road, Camp Springs, Maryland 20746-4320</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>July 5, 1996</b> <b>Maryland Veterans Cemetery</b>			
20c. LOCATION — City or Town, State <b>Cheltenham, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cardiac arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Chronic Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY</b> <b>28c. INJURY AT WORK?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>28d. DESCRIBE HOW INJURY OCCURRED</b> <b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rakesh Aroka, MD</b>			
29c. LICENSE NUMBER <b>D20108</b>				29d. DATE SIGNED (Month, Day, Year) <b>7/1/96</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RAKESH AROKA MD 14300 GALLANT FOX LN, BOWIE MD 20715</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 09 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21537

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT LAWRENCE COUCH</b>				2. Date of Death Month <b>JULY</b> Day <b>8</b> Year <b>1996</b>		3. Time of Death <b>12:50 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>53 FOREST PLACE</b>				4b. City, Town, or Location of Death <b>HUGHESVILLE</b>		4c. County of Death <b>CHARLES</b>	
Funeral Director	5. Social Security Number <b>231-46-5310</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>JUNE 15, 1937</b>	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>CHARLES</b>		10c. City, Town or Location <b>HUGHESVILLE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>53 FOREST PLACE</b>				10f. Zip Code <b>20637</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OWNER/OPERATOR CONSTRUCTION</b>		16b. Kind of Business/Industry <b>GENERAL CONSTRUCTION</b>		
17. Father's Name (First, Middle, Last) <b>JAMES E. COUCH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ESTHER E. PHILLIPS</b>				
19a. Informant's Name/Relationship (Type, Print) <b>GRACE I COUCH/SPOUSE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>53 FOREST PLACE HUGHESVILLE, MARYLAND 20637</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TRINITY MEMORIAL GARDENS</b>		Data <b>JULY 12</b>		20c. Location - City or Town, State <b>WALDORF, MARYLAND</b>		
21. Signature of Funeral Service Licensee  <b>BENJAMIN M. MATTHEWS M-000658</b>				22. Name and Address of Facility <b>THE HUNTT FUNERAL HOME, INC. P.O. BOX 156 WALDORF, MARYLAND 20604</b>				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Heart Attack</u> Due to (or as a consequence of): b. <u>Diabetes Mellitus</u> Due to (or as a consequence of): c. <u>Hypertension</u> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>MICHAEL SIDAROUS</b>		29c. License number <b>045365</b>		29d. Date signed (Month, Day, Year) <b>7-9-96</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>11701 Livingston Rd #101 Ft. Washington Md. 20744</b>								
31. Date filed (Month, Day, Year) <b>JUL 10 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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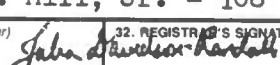
1975  
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96 21538

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELOISE M. COWGER</b>				2. DATE OF DEATH MONTH <b>July</b> DAY <b>3</b> YEAR <b>1996</b>		3. TIME OF DEATH <b>7:55 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-32-0901</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 17, 1914</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7434 Hayward Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Pocomoke City</b>		9c. COUNTY OF DEATH <b>Somerset</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Pocomoke City</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7434 Hayward Road</b>				10f. ZIP CODE <b>21851</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>— — —</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>At Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Tully F. Mears</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lydia Cutler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>W. Paul Cowger (husband)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7434 Hayward Road - Pocomoke City, MD 21851</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Presbyterian Cemetery 7/6/96</b>		DATE <b>7/6/96</b>		20c. LOCATION — City or Town, State <b>Pocomoke City, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>Robert H. Bradshaw</b>				22. NAME AND ADDRESS OF FACILITY <b>Bradshaw &amp; Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ALZHEIMERS Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aspiration Pneumonia</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Thomas C. Hill, Jr. MD Attending Physician</b>				29c. LICENSE NUMBER <b>D08008</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 5, 1996</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas C. Hill, Jr. - 108 Pine Bluff Road - Salisbury, MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 9 1996</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21539

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH ELIZABETH CORNWELL					2. Date of Death Month JULY Day 4 Year 1996		3. Time of Death 7:35 P.M.	
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL					4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 218-30-0425		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 25, 1915		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County Allegany	10c. City, Town or Location Cumberland				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 125 W. Second Street				10f. Zip Code 21502		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Supervisor				16b. Kind of Business/Industry Memorial Hospital		
	17. Father's Name (First, Middle, Last) Harry L. Cornwell					18. Mother's Name (First, Middle, Maiden Surname) Elizabeth (Morris)			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Dorothy Cornwell--sister-in-law					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 W. Second Street; Cumberland, MD 21502			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park		Date 07/07	20c. Location - City or Town, State Cumberland, MD			
	21. Signature of Funeral Service Licensee Nicholas J. Scarpelli				22. Name and Address of Facility Scarpelli Funeral Home Cumberland, MD 21502				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of): b. Arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 wks 50 yrs
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Guy Fiscus M.D.					29c. License number D 12779		29d. Date signed (Month, Day, Year) July 5 1996		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUY FISCUS M.D. MEMORIAL HOSPITAL MEDICAL BLDG. CUMBERLAND, MD 21502									
31. Date filed (Month, Day, Year) JUL 05 1996		32. Registrar's Signature John Davidson-Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 21540**  
**Certificate of Death**

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>ALICE PAULINE DUNN</b>					2. Date of Death Month <b>June</b> Day <b>26</b> Year <b>1996</b>		3. Time of Death <b>11:20 A.M.</b>		
	4e. Facility Name (If not institution, give street and number) <b>11360 Sharptown Rd.</b>					4b. City, Town, or Location of Death <b>Mardela Springs</b>		4c. County of Death <b>Wicomico</b>		
<b>Funeral Director</b>	5. Social Security Number <b>220-10-8325</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 10, 1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>			10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Mardela Springs</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>11360 Sharptown Rd.</b>					10f. Zip Code <b>21837</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>			16b. Kind of Business/Industry <b>Retail sales</b>		
17. Father's Name (First, Middle, Last) <b>Marion Phippin</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Giles</b>					
19a. Intendant's Name/Relationship (Type, Print) <b>Shirley Littleton</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11358 Sharptown Rd., Mardela Springs, MD 21837</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Memory Gardens</b>			Date <b>6/29/96</b>		20c. Location - City or Town, State <b>Hebron, MD</b>		
21. Signature of Funeral Service Licensee  <b>MO1051</b>					22. Name and Address of Facility <b>Holloway Funeral Home</b> <b>501 Snow Hill Rd., Salisbury, MD 21804</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>Cardiopulmonary arrest due to arrhythmia</b> 4 Months</p> <p>Due to (or as a consequence of):</p> <p>b. <b>Chronic obstructive Pulmonary disease</b> 20 years</p> <p>Due to (or as a consequence of):</p> <p>c.</p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 10%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
<p><b>- Deep vein thrombosis -</b></p> <p><b>- Right lung collapse - (lower lobe)</b></p>										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number <b>D15192</b>		29d. Date signed (Month, Day, Year) <b>6/26/96</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Backus MD 8133 Eastern Shore Dr. Salisbury, MD 21804</b>										
31. Date filed (Month, Day, Year) <b>JUN 28 1996</b>			32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21541

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FLORENCE E. Hauseman		2. Date of Death Month Day Year June 27 1996		3. Time of Death 1133
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 170-22-1273	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) September 13, 1925		9. Birthplace (State or Foreign Country) Pennsylvania		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Delaware	10b. County Sussex	10c. City, Town or Location Millsboro		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 241 W. Albermarle Court		10f. Zip Code 19966		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mint conveyor belt operator		16b. Kind of Business/Industry Candy Factory		
	17. Father's Name (First, Middle, Last) Elmer Spohn		18. Mother's Name (First, Middle, Maiden Surname) Florence Christman		
	19a. Informant's Name/Relationship (Type, Print) LeRoy M. Hauseman		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 241 W. Albermarle Ct., Millsboro, DE 19966		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Evans Crematory		20c. Location - City or Town, State 7/1/96 Reading, PA
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiac Failure</i> Due to (or as a consequence of): b. <i>Mitral Regurgitation</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate interval between Onset and Death 24hr 3-6 years				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier J S Julian MD		29c. License number 41813		29d. Date signed (Month, Day, Year) 6/27/96
	30. Name and address of person who completed cause of death (Form 23e) (Type, Print) J S Julian MD 201 Pine Bluff Rd Salisbury MD 21801				
31. Date filed (Month, Day, Year) JUN 28 1996		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





96 21542

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY Jane ELIZABETH Dryden				2. DATE OF DEATH MONTH DAY YEAR June 26 1996		3. TIME OF DEATH 3:00 A M	
4. SOCIAL SECURITY NUMBER 216-40-3838		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 27, 1914	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania		9a. FACILITY NAME (If not institution, give street and number) Wicomico Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Salisbury		9c. COUNTY OF DEATH Wicomico	
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 412 Monticello Ave.				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales lady		16b. KIND OF BUSINESS/INDUSTRY Dept/Clothing Store			
17. FATHER'S NAME (First, Middle, Last) Malcolm Sylvester Weaver				18. MOTHER'S NAME (First, Middle, Maiden Surname) Freda Amway			
19a. INFORMANT'S NAME (Type/Print) William M. Dryden				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1304 Woodland Rd., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parsons Cemetery 6/28		20c. LOCATION — City or Town, State Salisbury, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. N. Balbow</i>				22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>Chronic URI</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death <i>5 days</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Histomon's Disease</i> <i>Severely</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE NOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D02026		29d. DATE SIGNED (Month, Day, Year) June 27-96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) F.G. Arthes, MD 1622A Ocean Pines, Berlin, Md. 21811							
31. DATE FILED (Month, Day, Year) JUN 28 1996				32. REGISTRAR'S SIGNATURE <i>Jane Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21543

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RICHARD JAMES DAVIS</b>			2. Date of Death Month <b>6</b> - Day <b>29</b> - Year <b>1996</b>		3. Time of Death <b>0050</b>													
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>													
Funeral Director	5. Social Security Number <b>215-26-3842</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>1-15-31</b>	9. Birthplace (State or Foreign Country) <b>ACCOMAC CO., VA.</b>												
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State <b>MD.</b>	10b. County <b>WICOMICO</b>	10c. City, Town or Location <b>SALISBURY</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
	10e. Street and Number <b>526 E. WILLIAMS STREET</b>			10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>U.S.A.</b>													
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>KOREAN</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+) <b>0</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SENIOR INSPECTOR</b>		16b. Kind of Business/Industry <b>EQUIFAX SERVICES</b>													
	17. Father's Name (First, Middle, Last) <b>SAMUEL BARTHOLOMEW DAVIS</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARGUARITE CHESSER</b>															
	19a. Informant's Name/Relationship (Type, Print) <b>DOROTHY T. DAVIS</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>526 E. WILLIAMS ST. SALISBURY, MD. 21804</b>															
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY 7-1-96</b>		20c. Location - City or Town, State <b>SALISBURY, MD.</b>														
	21. Signature of Funeral Service Licensee <b>David H. Thompson</b> M01051		22. Name and Address of Facility <b>HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD., SALISBURY, MD. 21804</b>																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Severe Congestive Heart Failure</b></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Severe Aortic Sclerosis</b></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. <b>Severe Coronary Artery Disease</b></td> <td rowspan="2">17 yrs.</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____</td> <td></td> <td></td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)	a. <b>Severe Congestive Heart Failure</b>	Approximate Interval Between Onset and Death	Due to (or as a consequence of):	b. <b>Severe Aortic Sclerosis</b>	Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. <b>Severe Coronary Artery Disease</b>	17 yrs.	Due to (or as a consequence of):	d. _____	
Immediate Cause (Final disease or condition resulting in death)	a. <b>Severe Congestive Heart Failure</b>	Approximate Interval Between Onset and Death																	
	Due to (or as a consequence of):																		
	b. <b>Severe Aortic Sclerosis</b>																		
	Due to (or as a consequence of):																		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. <b>Severe Coronary Artery Disease</b>	17 yrs.																	
	Due to (or as a consequence of):																		
d. _____																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown													
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred														
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>David H. Thompson</b>		29c. License number <b>D47619</b>		29d. Date signed (Month, Day, Year) <b>6/29/96</b>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>OSCAR GUALTEROS 262 Tilghman Rd Salisbury MD 21804</b>																			
31. Date filed (Month, Day, Year) <b>JUL 01 1996</b>		32. Registrar's Signature <b>John Davidson Randall</b>																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21544

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Josephine Louise DeVaughn				2. Date of Death Month: June 12, 1996 Day: 12, Year: 1996		3. Time of Death 11:30 A.M.	
	4a. Facility Name (If not institution, give street and number) Manor Care Nursing Home				4b. City, Town, or Location of Death Largo		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 217-46-5828		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) June 12, 1915	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State: Maryland 10b. County: Prince George's 10c. City, Town or Location: Upper Marlboro 10d. Inside City Limits: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 11th College (1-4or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	
	16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) John Montgomery Norfolk		18. Mother's Name (First, Middle, Maiden Surname) Edith Brown		19a. Informant's Name/Relationship (Type, Print) Charles Joseph DeVaughn, Jr.	
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 Brown Station Road, Upper Marlboro, Md 20772		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Church Cemetery		20c. Location - City or Town, State Upper Marlboro, Md	
	21. Signature of Funeral Service Licensee D. S. S. S.		22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Pneumonia Due to (or as a consequence of): b. Dehydration Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 6/6/96 6/6/96	
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerosis Dementia Renal Calculus.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	
	28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Rakesh Chandra M.D.		29c. License number D 20108		29d. Date signed (Month, Day, Year) June 12, 1996	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Rakesh, 14300 Gallent Fox Lane #222, Bowie, Maryland 20715							
State Registrar	31. Date filed (Month, Day, Year) JUL 0 9 1996		32. Registrar's Signature John Davidson Randall					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21545

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY ELLSWORTH DONN JR</b>				2. Date of Death Month Day Year <b>July 5, 1996</b>		3. Time of Death <b>6:09 P</b>	
	4a. Facility Name (If not institution, give street and number) <b>Charlotte Hall Veterans Home</b>				4b. City, Town, or Location of Death <b>Charlotte Hall</b>		4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>579-05-0411</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 5, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>Washington DC</b>		10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Charlotte Hall</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>Charlotte Hall Veterans Home</b>		10f. Zip Code <b>20622</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>		16b. Kind of Business/Industry <b>Federal Government</b>			
	17. Father's Name (First, Middle, Last) <b>Harry Ellsworth Donn, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie UNKNOWN</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary Virginia Daniels</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2602 Ryder Ave, Forestville, Maryland 20747</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery</b>		20c. Location - City or Town, State <b>Cheltenham, Maryland</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Maryland 20735</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ALZHEIMER'S DISEASE</b> Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ulcerative Colitis, Squid Stricture</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D-25435</b>		29d. Date signed (Month, Day, Year) <b>7/8/96</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Mukesh Mathur 110 Hospital Rd, Prince Frederick, Md 20678</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 9 1996</b>		32. Registrar's Signature <b>[Signature]</b>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21546

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Virginia Davis				2. Date of Death Month Day Year July 9 1996		3. Time of Death 1255	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 216 14 6898		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 25 1912	
	9. Birthplace (State or Foreign Country) Virginia		10a. State MD.		10b. County Washington		10c. City, Town or Location Hagerstown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 415 N. Jonathan St.		10f. Zip Code 21740		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician		16b. Kind of Business/Industry Health Care		17. Father's Name (First, Middle, Last) William Banks	
	18. Mother's Name (First, Middle, Maiden Surname) Martha Johnson Banks		19a. Informant's Name/Relationship (Type, Print) Martha Cheeves		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 N. Jonathan St. Hagerstown, MD. 21740		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery		20c. Location - City or Town, State Hagerstown, MD		21. Signature of Funeral Service Licensee Thomas E. Watto		22. Name and Address of Facility Watsons Funeral Home 24 W. Bethel St Hagerstown, MD. 21740	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Aspiration Pneumonia Due to (or as a consequence of): c. Cerebrovascular accident Due to (or as a consequence of): d. HASCVD		Approximate Interval Between Onset and Death 2 days 1 week months years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Terry L. Corbels, M.D.		29c. License number DPU31	
State Registrar	29d. Date signed (Month, Day, Year) 7/9/96		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terry L. Corbels, M.D.		31. Date filed (Month, Day, Year) JUL 11 1996		32. Registrar's Signature John D. ...	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21547

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Cecil B. Dean</b>				2. Date of Death Month Day Year <b>JUNE 28 96</b>		3. Time of Death <b>11:25pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND Hospital</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>233-22-0261</b>		6. Sex <b>M</b> <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APRIL 18, 1916</b>	
	9. Birthplace (State or Foreign Country) <b>WEST VIRGINIA</b>		10. Usual Residence of Decedent		11. Merit Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>NORTH EAST</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>644 BAILIFF</b>		10f. Zip Code <b>21901</b>		10g. Citizen of What Country? <b>UNITED STATES</b>		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DUMP TRUCK DRIVER</b>		16b. Kind of Business/Industry <b>Excavation/Hauling</b>		17. Father's Name (First, Middle, Last) <b>EDGAR DEAN</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>PEARL CUTLER</b>		19a. Informant's Name/Relationship (Type, Print) <b>PAULINE B. DEAN</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>644 BAILIFF RD. PO BOX 445 NORTH EAST MD 21901</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Robert T. Curran</b>		22. Name and Address of Facility <b>CROUCH FUNERAL HOME 127 SOUTH MAIN STREET, NORTH EAST MD 21901</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MULTIPLE TRAUMA - PULMONARY CONCUSSION, RIB FRACTURES 12 days</b> Due to (or as a consequence of): <b>b. RESPIRATORY FAILURE 12 days</b> Due to (or as a consequence of): <b>c. MOTOR VEHICLE ACCIDENT 12 days</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTIPLE FRACTURES / LIMBS</b> <b>CLOSED HEAD INJURY - SEVERE WITH COMA</b>		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>06/16/96</b>	
	28b. Time of Injury <b>3:45 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>VEHICLE INTO TREE</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>644 Bailiff Road, North East Md, 21901</b>	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Robert T. Curran</b>		29c. License number <b>D23286</b>		29d. Date signed (Month, Day, Year) <b>JULY 01 / 96</b>	
	30. Name and address of person who completed cause of death (Item 22a) (Type, Print) <b>ROYAL MILES 22 S. GREENE ST. BALTIMORE MD 21201</b>		31. Date filed (Month, Day, Year) <b>JUL 05 1996</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

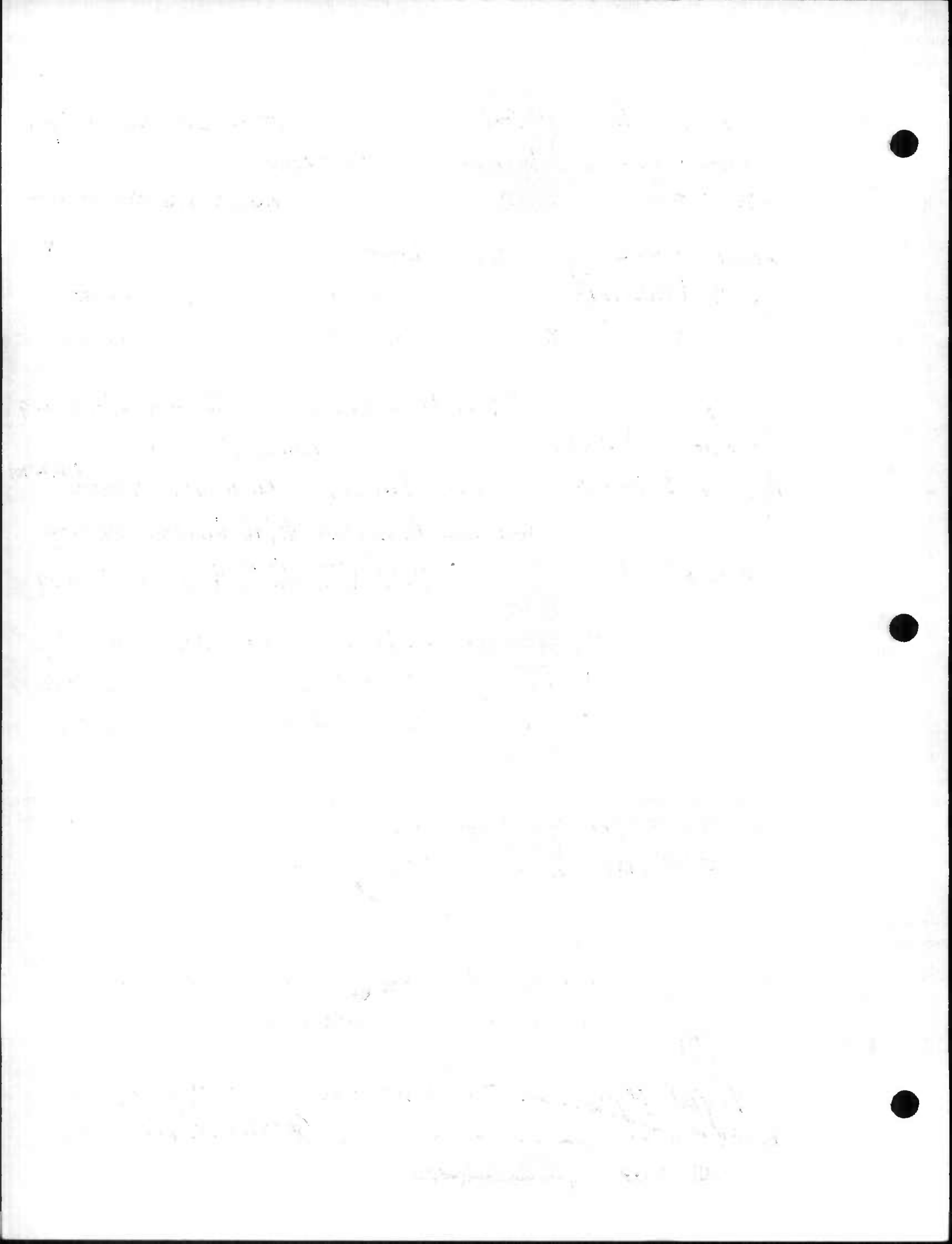
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

DHMH 16 Rev 6/95

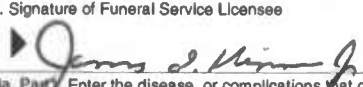
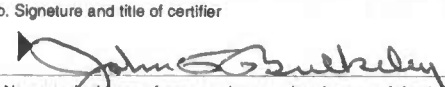


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21548

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Edward Doyle, Jr.				2. Date of Death Month 7 Day 3 Year 96		3. Time of Death 1600								
	4a. Facility Name (If not institution, give street and number) 306 South Camden Avenue				4b. City, Town, or Location of Death Fruitland		4c. County of Death Wicomico								
Funeral Director	5. Social Security Number 231-10-7393		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 2-21-17		9. Birthplace (State or Foreign Country) VIRGINIA						
	Usual Residence of Decedent														
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Fruitland				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
10e. Street and Number 306 South Camden Avenue				10f. Zip Code 21826		10g. Citizen of What Country? U.S.									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Control Room Operator			16b. Kind of Business/Industry Electrical Power								
17. Father's Name (First, Middle, Last) THOMAS EDWARD DOYLE, SR.					18. Mother's Name (First, Middle, Maiden Surname) CATHERINE ROCHE										
19a. Informant's Name/Relationship (Type, Print) Patrick Doyle-Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5000 Stock Creek Lane, Salisbury, Md. 21801											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 07/04/96		20c. Location - City or Town, State Salisbury, Maryland							
21. Signature of Funeral Service Licensee  M00295				22. Name and Address of Facility HINMAN FUNERAL HOME, INC. 11673 Somerset Avenue, Princess Anne, Md. 21853											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier  D.M.E.		29c. License number D03599		29d. Date signed (Month, Day, Year) 7-3-96	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John T. Bulkeley, M.D.; 108 Pine Bluff Road; Salisbury, Md. 21801															
31. Date filed (Month, Day, Year) JUL 08 1996				32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

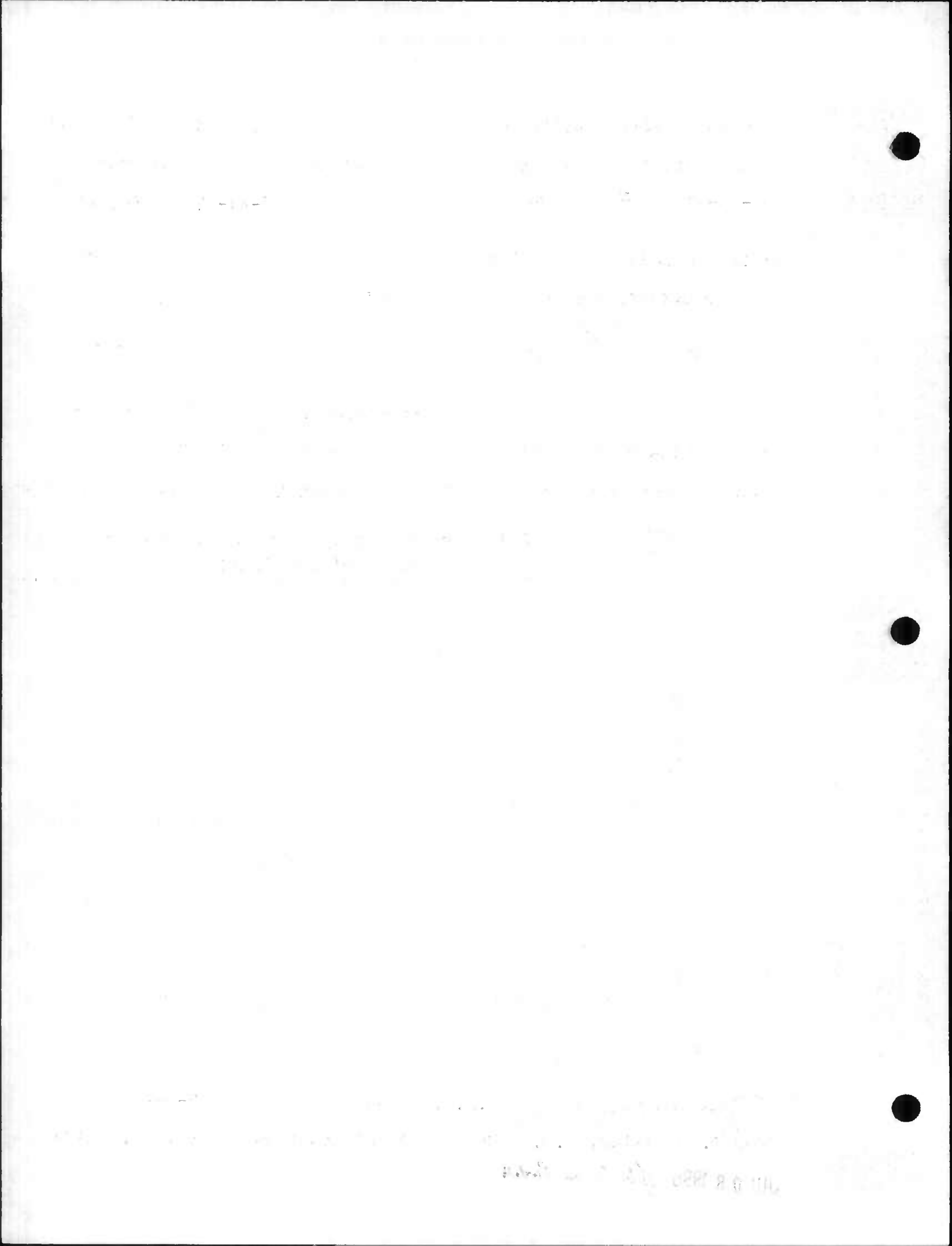
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21549

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY EDWARD DISHONG</b>				2. Date of Death Month <b>JULY</b> Day <b>02</b> Year <b>1996</b>		3. Time of Death <b>06:26A</b>	
	4a. Facility Name (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>215-10-2278</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 16 1917</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>ALLEGANY</b>		10c. City, Town or Location <b>CUMBERLAND</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>RFD#3 BEDFORD ROAD</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>10</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OWNER/OPERATOR SERVICE STATION</b>			16b. Kind of Business/Industry <b>GASOLINE/AUTO REPAIR</b>	
17. Father's Name (First, Middle, Last) <b>HARRY S. DISHONG SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>AGNES WINNER</b>				
19a. Informant's Name/Relationship (Type, Print) <b>SUSAN DISHONG DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RFD#3 BEDFORD ROAD CUMBERLAND MARYLAND 21502</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SUNSET CEMETERY JULY 5 1996</b>			20c. Location - City or Town, State <b>CUMBERLAND MARYLAND</b>	
21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility <b>MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>Renal Failure</b> Due to (or as a consequence of): b. <b>Polycystic Kidney Disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>5 years</b> <b>Congenital</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerotic Cardiovascular Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Wayne C. Spiggle</i>		29c. License number <b>D11443</b>		29d. Date signed (Month, Day, Year) <b>JULY 2, 1996</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. WAYNE SPIGGLE SETON DRIVE CUMBERLAND MARYLAND 21502</b>								
31. Date filed (Month, Day, Year) <b>JUL 08 1996</b>				32. Registrar's Signature <i>John A. Randall</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-1000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

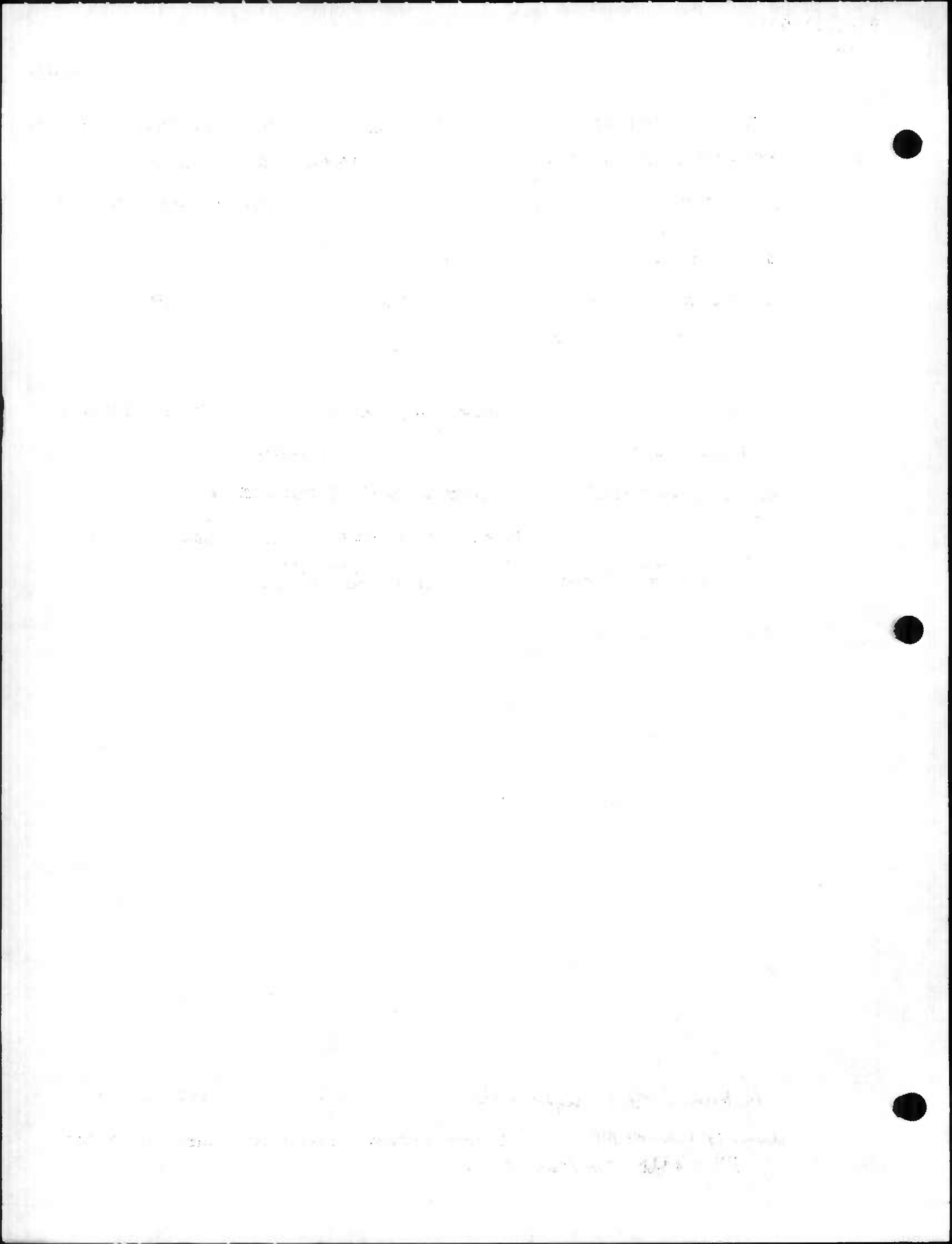
State of Maryland / Department of Health and Mental Hygiene

96 21550

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN MARSHALL DAVIS SR.</b>				2. Date of Death Month <b>JULY</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>8:06 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>MEMORIAL HOSPITAL E.R.</b>				4b. City, Town, or Location of Death <b>CUMBERLAND</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>217-42-7035</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>52</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 20, 1943</b>	
	10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Oldtown</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>Route 1 Box 62</b>				10f. Zip Code <b>21555</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Heavy Equip Operator</b>		16b. Kind of Business/Industry <b>Koppers Industry</b>			
	17. Father's Name (First, Middle, Last) <b>William C. Davis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Iris (Nethers)</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Bonnie J. Davis--wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1 Box 62; Oldtown, MD 21555</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		Data <b>07/10</b>		20c. Location - City or Town, State <b>Cumberland, MD</b>	
	21. Signature of Funeral Service Licensee <i>Jones F. Scarpelli</i>				22. Name and Address of Facility <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic cardiovascular disease</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>Donald G. Wright MD</i>				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JULY 6, 1996</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Donna G. Wright MD 111 Penn Street, Baltimore, Maryland 21201</b>							
	31. Date filed (Month, Day, Year) <b>JUL 8 1996</b>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21551

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR T. DuBREE

2. Date of Death

07/06/96

Day

Year

3. Time of Death

6:10P.M.

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home

4b. City, Town, or Location of Death

Denton, Maryland

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

212-03-4306

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

09/09/03

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Preston

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

410 Linchester Road

10f. Zip Code

21655

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Defense Department

16b. Kind of Business/Industry

Auto Mechanic

17. Father's Name (First, Middle, Last)

Steven Thomas DuBree

18. Mother's Name (First, Middle, Maiden Surname)

Florence Boyd

19a. Informant's Name/Relationship (Type, Print)

Laura E. DuBree

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

410 Linchester Rd., Preston, MD 21655

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Junior Order Cemetery 7/9

Date

20c. Location - City or Town, State

Preston, Maryland

21. Signature of Funeral Service Licensee

Michael J. Eskow

22. Name and Address of Facility

Frampton -Hawkins-Eskow Funeral Home  
PO Box 43, Federalsburg, MD 21632

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hip Fracture

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Sides MD

29c. License number

D31376

29d. Date signed (Month, Day, Year)

7-8-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Sides MD 920 Market St Denton MD

31. Date filed (Month, Day, Year)

JUL -9 96

32. Registrar's Signature

Sha Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21552

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MINNIE M. DAVIS</b>			2. Date of Death Month <b>JUNE</b> Day <b>28</b> Year <b>1996</b>		3. Time of Death <b>12:40 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SALISBURY CENTER: GENESIS ELDERCARE</b>			4b. City, Town, or Location of Death <b>SALISBURY, MD.</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>219-07-5300</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>02/03/14</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10e. State <b>MD</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>200 Civic Avenue</b>			10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)		18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Factory Worker</b>		16b. Kind of Business/Industry <b>Food Processing</b>		
17. Father's Name (First, Middle, Last) <b>John W. Sampson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary E. Sampson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Marietta Kiah</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4023 Fairview Ave., Baltimore, MD 21216</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chester Cemetery</b>		20c. Location - City or Town, State <b>7-2-96 Rhodesdale, MD</b>			
21. Signature of Funeral Service Licensee <b>Michael F. Eskow</b>				22. Name and Address of Facility <b>Frampton-Hawkins-Eskow Funeral Home PO Bx 43, Federalsburg, MD 21632</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Metastatic Colon Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death <b>9 mos</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Advanced Dementia</b> <b>COPD</b> <b>Ischemic Heart Disease</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
25. Was data referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>Michael F. Eskow</b>				29c. License number <b>D-39813</b>		29d. Date signed (Month, Day, Year) <b>6/28/96</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>							
31. Date filed (Month, Day, Year) <b>JUL - 2 '96</b>				32. Registrar's Signature <b>John W. Sampson - Handell</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21553

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth Bruce Edwards, Jr.				2. Date of Death Month Day Year July 5, 1996		3. Time of Death 1:17 P.M.		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 214-34-0573	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 4, 1936	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Washington	10c. City, Town or Location Gapland			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 3409 Kaetzel Road			10f. Zip Code 21779		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carman			16b. Kind of Business/Industry Railroad			
	17. Father's Name (First, Middle, Last) Kenneth Bruce Edwards, Sr.				18. Mother's Name (First, Middle, Maiden Summa) Evelyn Oneida Badger				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Agnes V. Edwards - Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Kaetzel Road - Gapland, MD 21779					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Brownsville Heights Cem.		Date 7/8		20c. Location - City or Town, State Brownsville, Maryland		
	21. Signature of Funeral Service Licensee Robert L. Spencer			22. Name and Address of Facility Eackles-Spencer Funeral Home Harpers Ferry, WV 25425					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. SQUAMOUS CELL LUNG CANCER Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Neil Warandekar MD				29c. License number DA7611		29d. Date signed (Month, Day, Year) 7/8/96			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIL WARANDEKAR, MD, 1475 TANEY AVE. #204, FREDERICK, MD 21702									
31. Date filed (Month, Day, Year) JUL 08 1996		32. Registrar's Signature John A. Buckner-Randall							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21554

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian Caroline Eddy</b>			2. Date of Death Month <b>July</b> Day <b>03</b> Year <b>1996</b>			3. Time of Death <b>1910pm</b>													
	4a. Facility Name (If not institution, give street and number) <b>Washington County Hospital</b>			4b. City, Town, or Location of Death <b>Hagerstown</b>			4c. County of Death <b>Washington</b>													
Funeral Director	5. Social Security Number <b>200-24-1467</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 10, 1927</b>		9. Birthplace (State or Foreign Country) <b>Sharpe, PA</b>											
	Usual Residence of Decedent			10e. State <b>PA</b>			10b. County <b>Fulton</b>			10c. City, Town or Location <b>Mercersburg</b>										
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			10e. Street and Number <b>RD 3 Box 79</b>			10f. Zip Code <b>17236</b>			10g. Citizen of What Country? <b>USA</b>										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurses Assistant</b>			16b. Kind of Business/Industry <b>Health Services</b>													
	17. Father's Name (First, Middle, Last) <b>William H. Keefer</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Irene Johnson</b>													
	19a. Informant's Name/Relationship (Type, Print) <b>Calvin V. Eddy</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RD 3 Box 79 Mercersburg, PA 17236</b>													
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Antioch Christian Cemetery</b>			20c. Location - City or Town, State <b>Big Cove Tannery, PA</b>													
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Grove Funeral Home</b> <b>P.O. Box 368 Hancock, MD 21750</b>																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia</b> Due to (or as a consequence of): <b>Chronic obstructive pulmonary disease</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Approximate Interval Between Onset and Death <b>3 days</b>										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Non Hodgkins lymphoma</b> <b>Auto immune hemolytic anemia</b>									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury <b>M</b>			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28d. Describe how injury occurred	
29a. Certifier (Print only) <b>Frederic H. Kass III</b>			29b. Signature and title of certifier 			29c. License number <b>1523823</b>			29d. Date signed (Month, Day, Year) <b>7/4/96</b>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frederic H. Kass III md 1799 Howell Rd Hagerstown MD</b>								
31. Date filed (Month, Day, Year) <b>JUL 18 1996</b>			32. Registrar's Signature 																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21555

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WAYNE ELMER FEAGA

2. Date of Death

Month Day Year  
JULY 3, 1996

3. Time of Death

2:08 pm

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

220-10-5098

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 19  
January 16, 19

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

902 Pine Avenue

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Warehouse Foreman

16b. Kind of Business/Industry

Janitorial Supply Co.

17. Father's Name (First, Middle, Last)

William C. Feaga

18. Mother's Name (First, Middle, Maiden Surname)

Blanche V. Staley

19a. Informant's Name/Relationship (Type, Print)

Eleanor S. Feaga

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

902 Pine Avenue, Frederick, MD 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hagerstown Crematory

Date

7-6-96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

T. T. B. MacKay

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.  
1621 Opossumtown Pike, Frederick, MD 2170223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. coronary artery disease  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

19 years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

K. S. Suleman

29c. License number

221648

29d. Date signed (Month, Day, Year)

7/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

710 W 9th St. Frederick MD 21701

31. Date filed (Month, Day, Year)

JUL 08 1996

32. Registrar's Signature

John Davidson-Randall

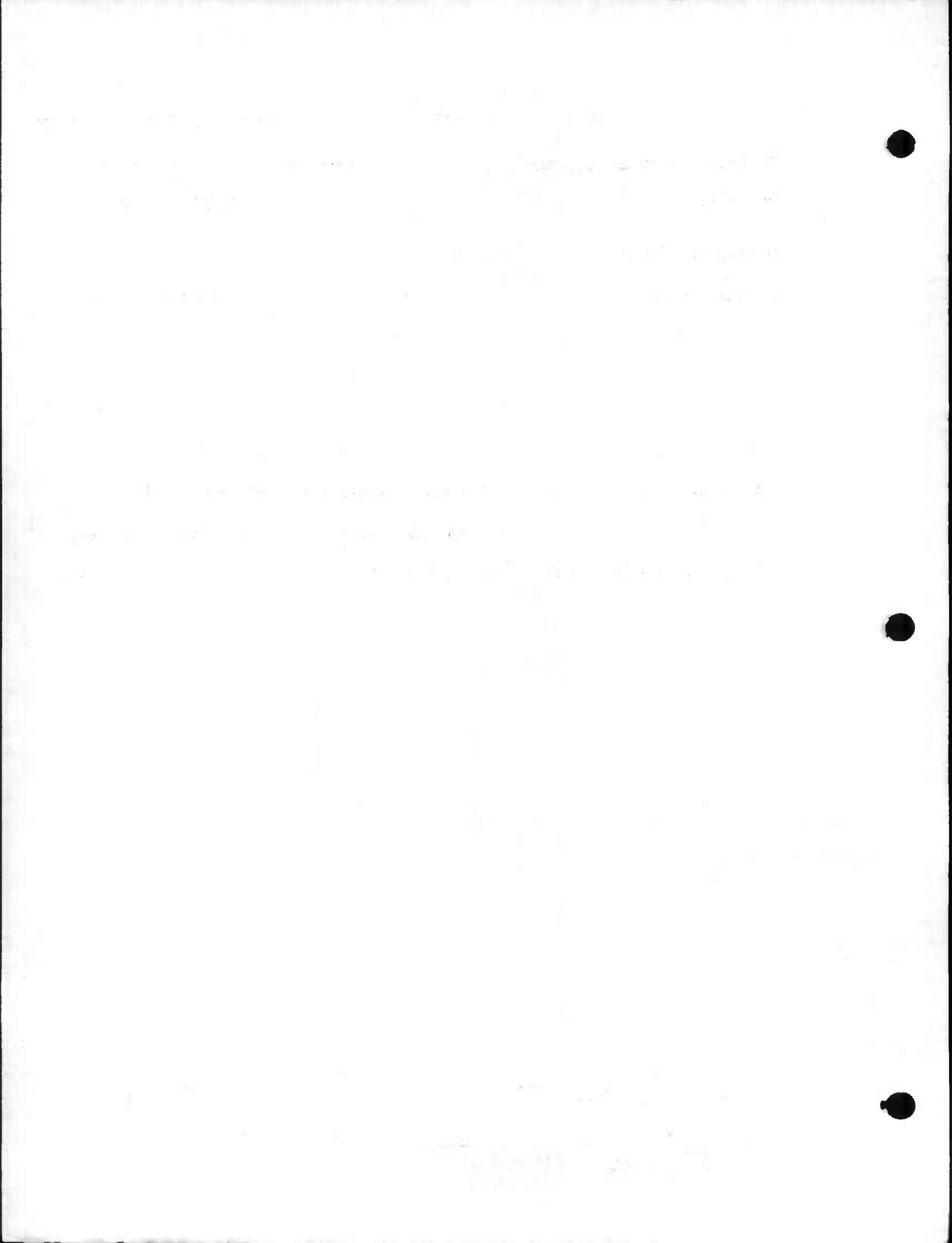
State  
Registrar

Baltimore, Maryland 21215-0020

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Département of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21556

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dr. DONALD F FLETCHER JR

2. Date of Death

Month  
07Day  
03Year  
96

3. Time of Death

0100

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

420-14-2110

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

01-10-18

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

Accomack

10c. City, Town or Location

Atlantic

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

34164 Wright Road

10f. Zip Code

213303

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Doctor

16b. Kind of Business/Industry

Private Practice

17. Father's Name (First, Middle, Last)

Donald F. Fletcher, Sr

18. Mother's Name (First, Middle, Maiden Surname)

Elodie Jones

19a. Informant's Name/Relationship (Type, Print)

Susan M. Fletcher (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 Winterquarters Drive, Pocomoke City, Md. 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

John W. Taylor Memorial Cem. 7/7/96 Temperanceville, Va.

Date

7/7/96

20c. Location - City or Town, State

Temperanceville, Va.

21. Signature of Funeral Service Licensee

Scott S. Melson

22. Name and Address of Facility

Melson Funeral Home  
10. Box 64, Pocomoke City, Md. 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John T. Bulkeley D.M.E.

29c. License number

D03599

29d. Date signed (Month, Day, Year)

07-03-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801

31. Date filed (Month, Day, Year)

JUL 08 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21557

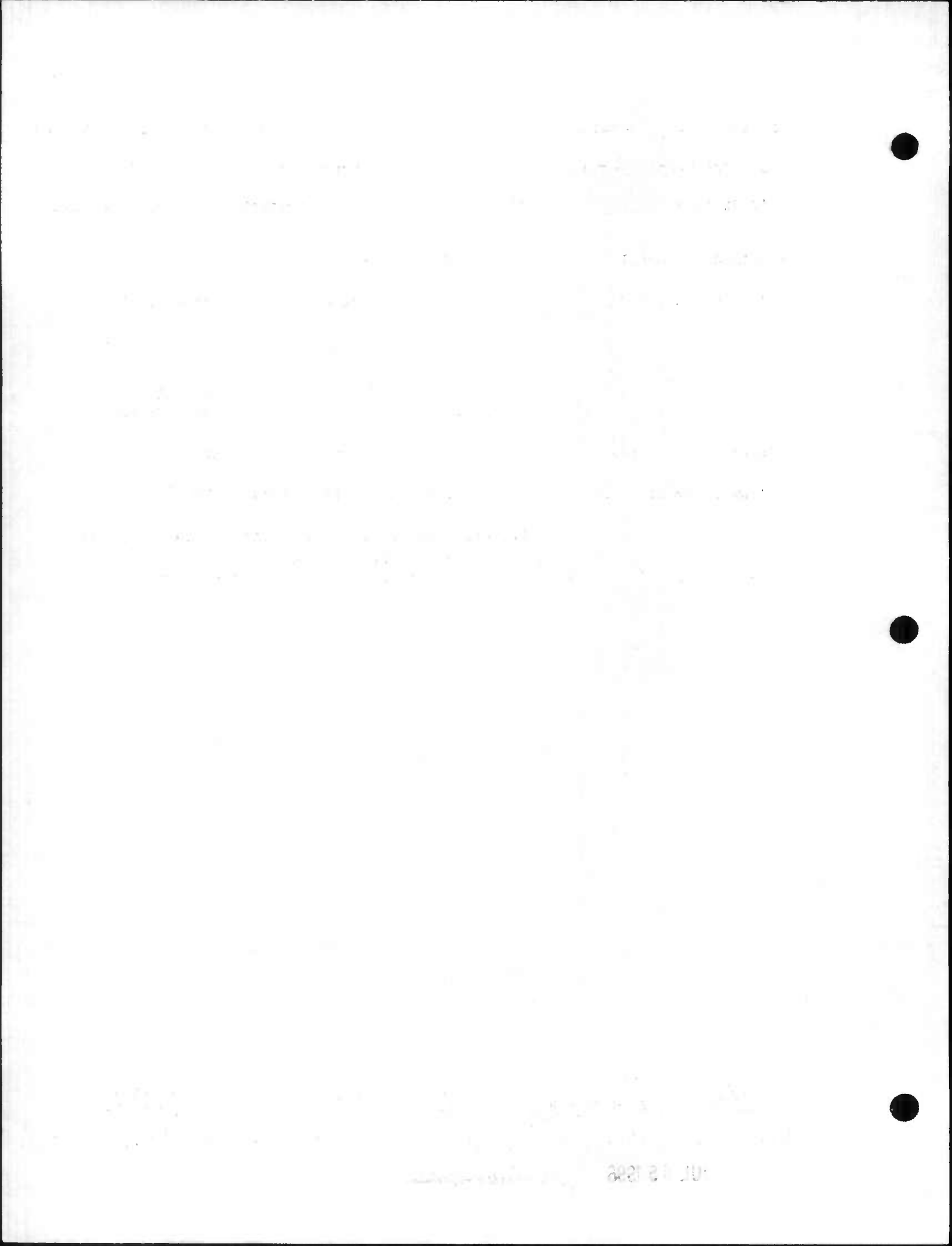
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bertha C. Fockler				2. Date of Death Month Day Year July 2 1996		3. Time of Death 1:55 a.m.	
	4e. Facility Name (If not institution, give street and number) 302 East Cecil Avenue				4b. City, Town, or Location of Death North East		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 212-38-4289		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) September 29 1903	
	10e. State Maryland		10b. County Cecil		10c. City, Town or Location North East		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 302 East Cecil Avenue				10f. Zip Code 21901		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Education/High School	
	17. Father's Name (First, Middle, Last) William J. Cameron				18. Mother's Name (First, Middle, Maiden Surname) Henrietta J. Smith			
	19e. Informant's Name/Relationship (Type, Print) Edwin B. Fockler, III				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 East Main Street, Elkton, MD 21921			
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary Anne's Cemetery		Date 7/5/96		20c. Location - City or Town, State North East, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD 21901			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Cardiovascular disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number D46467		29d. Date signed (Month, Day, Year) 07/03/96	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Heila Kirdani-Ryan, MD, 111 West High Street, Suite 204, Elkton, MD 21921							
	31. Date filed (Month, Day, Year) JUL 05 1996				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





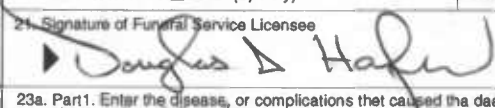
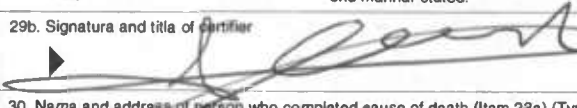
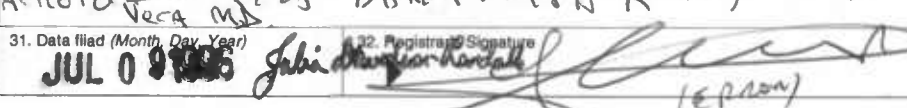
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21558

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>JAMES EDWARD FADELEY</b>				2. Date of Death Month <b>JULY</b> Day <b>6</b> , Year <b>1996</b>		3. Time of Death <b>11:15PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>32 LAVALE BLVD</b>				4b. City, Town, or Location of Death <b>LAVALE</b>		4c. County of Death <b>ALLEGANY</b>	
Funeral Director	5. Social Security Number <b>217-28-0170</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 22 1930</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedant							
10a. State <b>MARYLAND</b>		10b. County <b>ALLEGANY</b>		10c. City, Town or Location <b>LAVALE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>32 LAVALE BLVD</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>U S A</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedant Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>2/17/55</b> <b>2/7/57</b>		13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MECHANIC</b>		16b. Kind of Business/Industry <b>AUTOMOTIVE/EQUIPMENT</b>		
17. Father's Name (First, Middle, Last) <b>MELVIN FADELEY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>RUTH MCKENZIE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MARTHA MARIE FADELEY</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>32 LAVALE BLVD LAVALE, MARYLAND 21502</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EMMANUEL METHODIST CEM 7/9</b>		20c. Location - City or Town, State <b>FINZEL, MARYLAND</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HAFFER FROSTMANSON FUNERAL HOME</b> <b>58 FROST AVE FROSTBURG, MARYLAND 21532</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Lung Cancer</b> Due to (or as a consequence of): b. <b>Smoking</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>6 mo</b> <b>More 15 yrs</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Malnutrition</b>								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D91980</b>		29d. Date signed (Month, Day, Year) <b>JULY 8/96</b>		
30. Name and address of person who completed cause of death (Item 28a) (Type, Print) <b>Arnold Vega MD 925 Bishop Whistler Road, Cumberland MD 21502</b>								
31. Date filed (Month, Day, Year) <b>JUL 0 9 1996</b>								
32. Registrar's Signature  (EPSON)								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 902-6902.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

7+1  
NLS

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

96 21559

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Catherine McGovern Carrigan Forhane				2. DATE OF DEATH MONTH DAY YEAR July 3 1996		3. TIME OF DEATH 11:30 a m	
4. SOCIAL SECURITY NUMBER 096-16-5335-A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 21 1907	
8a. FACILITY NAME (If not institution, give street and number) Chestertown Nursing & Rehabilitation				9b. CITY, TOWN OR LOCATION OF DEATH Chestertown		9c. COUNTY OF DEATH Kent	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Queen Anne		10c. CITY, TOWN OR LOCATION Sudlersville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 163				10f. ZIP CODE 21668		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) chef		16b. KIND OF BUSINESS/INDUSTRY self employed	
17. FATHER'S NAME (First, Middle, Last) John Carrigan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth McGovern			
19a. INFORMANT'S NAME (Type/Print) Michael J. Forhane				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Pinechip Rd., Chestertown, MD 21620			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Captial Crematory 7/		20c. LOCATION — City or Town, State Dover, Delaware			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home P.O. Box 160 Greensboro, MD 21639			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal Failure</i>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Nephrosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Diabetes</i> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ASCVD, Peripheral vascular disease, Hypoproliferative Anemia, early gangrene feet</i>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D00354		29d. DATE SIGNED (Month, Day, Year) 7/31/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) C. Gottfried Baumann, M.D. 100 Brown St. Chestertown, Md. 21620							
31. DATE FILED (Month, Day, Year) Jul - 8 '96				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 21560

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Ellen GRIMM				2. DATE OF DEATH MONTH DAY YEAR July 6 1996		3. TIME OF DEATH 10:15 p.m.	
4. SOCIAL SECURITY NUMBER 217-07-0680		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 98 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec 28 1897	
8a. FACILITY NAME (If not institution, give street and number) Colton Villa Nursing Home				8b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		8c. COUNTY OF DEATH Washington	
10a. STATE Maryland				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 11421 Manse Road				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Her own home			
17. FATHER'S NAME (First, Middle, Last) John Lewis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Boppe			
19a. INFORMANT'S NAME (Type/Print) Betty J. Grimm /Daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11421 Manse Road Hagerstown, Md. 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 7/11/96		20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott D. Minnich</i>				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Heart Failure</i>							
b. <i>Chronic Atrial Fibrillation</i>							
c. <i>Colon Carcinoma</i>							
d. <i>History of breast ca</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>History of GI bleeding</i> <i>Hypertension</i> <i>Anemia</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jerry L. Coppes M.D.</i>				29c. LICENSE NUMBER DEFL 37		29d. DATE SIGNED (Month, Day, Year) 7/7/96	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JERRY L. COPPES M.D., 750 Dual Hwy. Hagerstown, MD							
31. DATE FILED (Month, Day, Year) JUL 09 1996				32. REGISTRAR'S SIGNATURE <i>J. M. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100

SECRET

RECEIVED 12/11/51

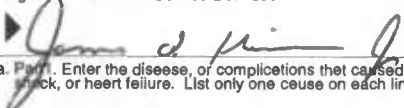
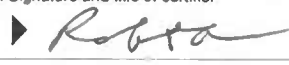
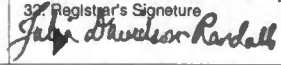
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21561

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES EDWARD Hopkins</b>		2. Date of Death Month <u>June</u> Day <u>22</u> Year <u>1996</u>		3. Time of Death <u>1800</u>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>224-18-2726</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>NOV 23, 1919</b>		9. Birthplace (State or Foreign Country) <b>DEL.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>VA.</b>	10b. County <b>ACCOMACK</b>	10c. City, Town or Location <b>MEARS</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>12969 CATTAIL ROAD</b>		10f. Zip Code <b>23409</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK/SALES</b>		16b. Kind of Business/Industry <b>HARDWARE</b>		
	17. Father's Name (First, Middle, Last) <b>EDWARD HOPKINS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE SMITH</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>JOYCE AILENE HOPKINS</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12969 CATTAIL ROAD-MEARS, VA. - 23409</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GROTON'S CEMETERY</b>		20c. Location - City or Town, State <b>6-26-96 HALLWOOD, VA.</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>THORNTON, FUNERAL HOME P.O. BOX 264, parksley, va. 23421</b>		
Physician /Medical Examiner	23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <u>RENAL FAILURE</u> Due to (or as a consequence of):  b. <u>METASTATIC CANCER</u> Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____				Approximate interval Between Onset and Death <u>3 wks.</u>
	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier 		29c. License number <b>D29168</b>		29d. Date signed (Month, Day, Year) <b>6/22/96</b>
	30. Name and address of person who completed cause of death (item 23e) (Type, Print) <b>Robert Allen MD 560 Riverside DR, A204 Salisbury, Md. 21801</b>				
31. Date filed (Month, Day, Year) <b>JUL 01 1996</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21562

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John A. Harris, Jr.						2. Date of Death Month Day Year July 6, 1996		3. Time of Death 7:49 a.m.	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital						4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 415-28-1490		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) March 2, 1926		9. Birthplace (State or Foreign Country) Tennessee	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State Maryland		10b. County Frederick		10c. City, Town or Location Monrovia				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 4559 Kempton Court				10f. Zip Code 21770		10g. Citizen of What Country? American			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Public Affairs Director			16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) John A. Harris, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Alice Neville			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gwen G. Harris - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4559 Kempton Court, Monrovia, Maryland 21770					
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		Date 7/10/96		20c. Location - City or Town, State Frederick, Maryland			
	21. Signature of Funeral Service Licensee <i>Olin L. Molesworth</i>				22. Name and Address of Facility Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>CARDIOGENIC SHOCK</u> Due to (or as a consequence of): b. <u>ACUTE ANTEROLATERAL MYOCARDIAL INFARCTION</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DIABETES MELLITUS</u> <u>HYPERTENSION</u>									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>John A. Vitarello MD</i>				29c. License number 027544		29d. Date signed (Month, Day, Year) 7/6/96			
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John A. Vitarello, M.D. 310 W 9th Street, Frederick, Maryland 21701									
	31. Date filed (Month, Day, Year) JUL 08 1996				32. Registrar's Signature <i>John A. Vitarello</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 21563

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edith Anne Holmes				2. DATE OF DEATH MONTH DAY YEAR July 5 1996		3. TIME OF DEATH 7:45 a m	
4. SOCIAL SECURITY NUMBER 252-19-7089		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 6, 1918	
9a. FACILITY NAME (If not institution, give street and number) 3409 Kemptown Church Road				9b. CITY, TOWN OR LOCATION OF DEATH Monrovia		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Monrovia		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3409 Kemptown Church Road				10f. ZIP CODE 21770		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Earl Armstrong				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice May DeGroot			
19a. INFORMANT'S NAME (Type/Print) Julie A. Holmes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Kemptown Church Road, Monrovia, Maryland 21770			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium Inc. 7/6		20c. LOCATION — City or Town, State Bethesda, Maryland.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth Funeral Home P.A. 26401 Ridge Road. Damascus, Md. 20872			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 40 years
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF):					40 years
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER PA M0047454L		29d. DATE SIGNED (Month, Day, Year) JULY 5, 1996	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8901 WISCONSIN AVE. BETHESDA MD 20889							
31. DATE FILED (Month, Day, Year) JUL 8 1996				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No.

96 21564

**Medical Certification: To Be Completed by Physician/Medical Examiner**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21565

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RAYMOND CALVIN HAINES</b>				2. Date of Death Month <b>JULY</b> Day <b>2</b> Year <b>1996</b>		3. Time of Death <b>0845 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>345 N. SPRINGDALE ROAD</b>				4b. City, Town, or Location of Death <b>WESTMINSTER</b>		4c. County of Death <b>CARROLL</b>	
Funeral Director	5. Social Security Number <b>218-38-1648</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 15, 1916</b>	
	Usual Residence of Decedent <b>Maryland</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. State <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>345 N. Springdale Rd.</b>		10f. Zip Code <b>21158</b>		10g. Citizen of What Country? <b>U.S.A.</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer</b>		16b. Kind of Business/Industry <b>Agriculture</b>			
	17. Father's Name (First, Middle, Last) <b>William Eldreges Haines</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edna Idle Morgan</b>			
	19. Informant's Name/Relationship (Type, Print) <b>Anna Haines</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>345 N. Springdale Rd. Westminster, Md. 21158</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Piney Creek Church</b>		Date <b>7/4/96</b>		20c. Location - City or Town, State <b>Taneytown, Maryland</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Fletcher Funeral Home</b> <b>254 E. Main Street, Westminster, Md. 21157</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arteriosclerotic Cardiovascular Disease</b>							
	23b. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JULY 2, 1996</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>JUL 8 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21566

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Lenora Hahn				2. Date of Death Month Day Year July 3 1996		3. Time of Death 1:10 AM	
	4a. Facility Name (If not institution, give street and number) Frederick Health Care Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 212-14-7294		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) June 11, 1907	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Woodsboro	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 204 S. Second St.		10f. Zip Code 21798		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) clerical/office worker		16b. Kind of Business/Industry perfume co.			
	17. Father's Name (First, Middle, Last) Robert J. Donsife		18. Mother's Name (First, Middle, Maiden Surname) Celeste Estella Morgan		19a. Informant's Name/Relationship (Type, Print) Donald R. Hahn/ son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 162 Woodsboro, MD 21798	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Hope Cemetery		20c. Location - City or Town, State 7/5/96 Woodsboro, MD			
	21. Signature of Funeral Service Licensee <i>Catharine D. Haggler</i>		22. Name and Address of Facility Hartzler Funeral Home Woodsboro, MD		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. End stage Congestive Heart Failure 6 months Due to (or as a consequence of): b. Ischemic Cardiomyopathy 6 months Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated.		29b. Signature and title of certifier <i>James S. Grissom</i> M.D.		29c. License number 021944		29d. Date signed (Month, Day, Year) 7/31/96	
	30. Name and address of person who completed causa of death (Item 23a) (Type, Print) James S. Grissom 1475 Taney Ave. Frederick, MD 21701							
	31. Date filed (Month, Day, Year) JUL 8 1996		32. Registrar's Signature <i>John Anderson-Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21567

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM F. HOBBS</b>		2. Date of Death Month <b>JULY</b> Day <b>5</b> Year <b>1996</b>		3. Time of Death <b>5:20 AM</b>
	4e. Facility Name (If not institution, give street and number) <b>3415 NORTH HIGH STREET</b>		4b. City, Town, or Location of Death <b>OLNEY</b>		4c. County of Death <b>MONTGOMERY</b>
Funeral Director	5. Social Security Number <b>577-07-8564</b>	8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		8. Date of Birth (Month, Day, Year) <b>NOV. 4, 1909</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MARYLAND</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>OLNEY</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>3415 NORTH HIGH STREET</b>		10f. Zip Code <b>20832</b>		10g. Citizen of What Country? <b>UNITED STATES</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ELECTRONICS TECHNICIAN</b>		16b. Kind of Business/Industry <b>TELEPHONE COMPANY</b>		
	17. Father's Name (First, Middle, Last) <b>FRENCH HOBBS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH S. RICKETTS</b>		
	19e. Informant's Name/Relationship (Type, Print) <b>MARGARET G. HOBBS, WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3415 NORTH HIGH STREET, OLNEY, MD. 20832</b>		
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. CARMEL CEMETERY</b>		20c. Location - City or Town, State <b>7/8/96 SUNSHINE, MARYLAND</b>
	21. Signature of Funeral Service Licensee <i>Muriel H. Barber</i>		22. Name and Address of Facility <b>MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. myocardial INFARction</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>IMMEDIATE</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Cerebrovascular Accident</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <i>John A. Shuler MD</i>		29c. License number <b>D18726</b>		29d. Date signed (Month, Day, Year) <b>JULY 5, 1996</b>
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>18111 Parma Philip Dr, Olney, MD 20832</b>				
31. Date filed (Month, Day, Year) <b>JUL 18 1996</b>		32. Registrar's signature <i>John A. Shuler</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

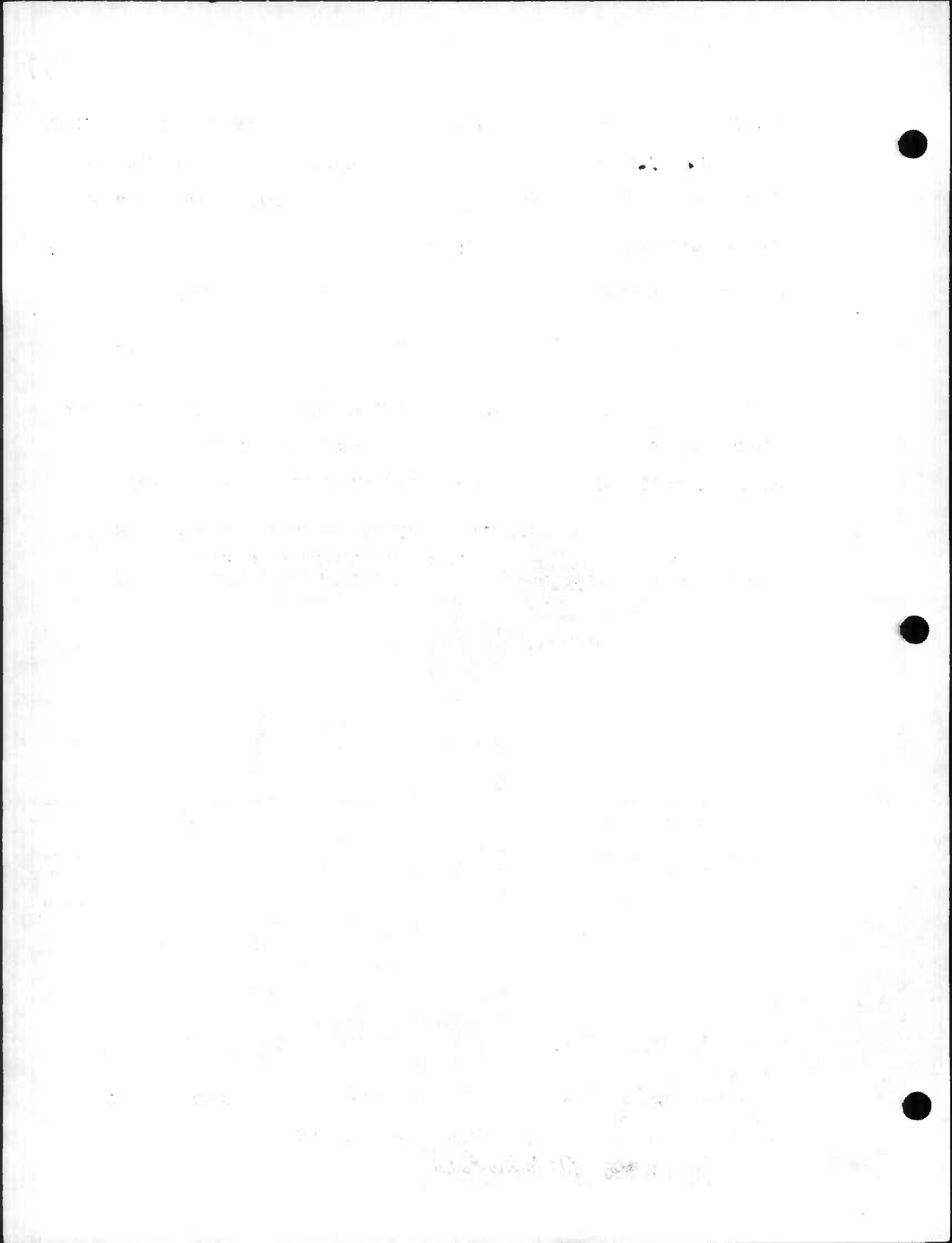
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



96-3411-011

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
 ITEMS: 23 PART I, II, 27, State of Maryland / Department of Health and Mental Hygiene  
 PER MEO FILM G-737 7/18/96 t.t

96 21568

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DENNIS GORDON HALL</b>				2. Date of Death Month <b>JUNE</b> Day <b>22</b> Year <b>1996</b>		3. Time of Death <b>10:05A/M</b>	
	4a. Facility Name (If not institution, give street and number) <b>EASTON MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>	
Funeral Director	5. Social Security Number <b>214-44-6442</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10-16-1946</b>	9. Birthplace (State or Foreign Country) <b>W.Va.</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Md.</b>	10b. County <b>Carline</b>	10c. City, Town or Location <b>Ridgely</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>212 Oriole Ave.</b>			10f. Zip Code <b>21660</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> Collage (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Mechanic</b>		16b. Kind of Business/Industry <b>Tool Mfg.</b>			
	17. Father's Name (First, Middle, Last) <b>Walter Hall</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Marjorie Haas</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Barbara Hall (wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>212 Oriole Ave Ridgely Md. 21660</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Capitol Crematory</b>		Date <b>6/24</b>	20c. Location - City or Town, State <b>Dover Del.</b>		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>P.O. Box 160 Fleegle- Helfenbein Greensboro Md. 21639</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Immediata Causa (Final disease or condition resulting in death)</b> <b>a. DILATED CARDIOMYOPATHY</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequentially list conditions, if any, leading to Immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>CONTRIBUTORY; CIRRHOSIS OF LIVER</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of causa of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JUNE 23, 1996</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>MARYANN A. KOREN MD 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>JUL 1 8 1996</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21569

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GLORIA ELAINE

2. Date of Death

Month Day Year  
July 5 1996

3. Time of Death  
1900

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

578-20-4364

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
7-30-23

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Worcester

10c. City, Town or Location

Ocean City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1916 Marlin Dr.

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary Secondary (0-12)

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Tilghman Redmond

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca McElvany

19a. Informant's Name/Relationship (Type, Print)

C.R. Harman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1916 Marlin Dr. Ocean City, Md.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge M.P.

Date

7-9

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Ullrich Funeral Home Berlin, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *uremia*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*weeks*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *end-stage kidney failure*  
Due to (or as a consequence of):

*months*

c. *chronic glomerulonephritis*  
Due to (or as a consequence of):

*years*

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*severe congestive cardiac dysfunction*  
*COPD, CVA*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Cynthia J. Tan M.D.*

29c. License number

29d. Date signed (Month, Day, Year)

*7/6/96*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Tan, Constantine 507-D Riverside Dr. Salisbury MD 21801*

31. Date filed (Month, Day, Year)

*JUL 08 1996*

32. Registrar's Signature

*St. Anselm Randall*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

... 10-12-4 ...

... 10-12-4 ...

... 10-12-4 ...

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... 10-12-4 ...



Amend # 7 wash co. J.B. July 12, 1996 21570

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DANIEL CLARENCE HARSHMAN				2. DATE OF DEATH MONTH DAY YEAR July 9 1996		3. TIME OF DEATH 12:30 A M					
4. SOCIAL SECURITY NUMBER 218-03-4554		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 29, 1996		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 10601 Church Hill Road				9b. CITY, TOWN OR LOCATION OF DEATH Myersville			9c. COUNTY OF DEATH Frederick				
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Myersville			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 10601 Church Hill Road		10f. ZIP CODE 21773		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dairy Farmer		16b. KIND OF BUSINESS/INDUSTRY Dairy Farm					
17. FATHER'S NAME (First, Middle, Last) Welty C. Harshman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Hauver							
19a. INFORMANT'S NAME (Type/Print) Pauline E. Harshman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10601 Church Hill Road, Myersville, MD 21773							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. John's Lutheran Cemt 7/12/96		DATE 7/12/96		20c. LOCATION — City or Town, State Myersville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Pauline E. Harshman</i>				22. NAME AND ADDRESS OF FACILITY P.O. Box 136 Ricketts Funeral Home 504 Main St. Myersville, MD 21773							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>lung cancer</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death 8 months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Pauline E. Harshman MD</i>				29c. LICENSE NUMBER D46473		29d. DATE SIGNED (Month, Day, Year) 7/10/96			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hind Harshman, 363 S. Cleveland Ave, Hagerstown, MD, 21740											
31. DATE FILED (Month, Day, Year) JUL 10 1996				32. REGISTRAR'S SIGNATURE <i>John Anderson</i>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21571

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wilson Couden Holmes

2. Date of Death

Month Day Year  
July 5 1996

3. Time of Death

0520

4a. Facility Name (If not institution, give street and number)

Union Hospital of Cecil County

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

221-18-7267

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
October 31, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

210 Thomas Avenue

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

9

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Ship-fitter &amp; welder

16b. Kind of Business/Industry

Ship Building

17. Father's Name (First, Middle, Last)

Alfred Holmes

18. Mother's Name (First, Middle, Maiden Summa)

Florence Erma Reynolds

19a. Informant's Name/Relationship (Type, Print)

Amalia V. Holmes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

210 Thomas Avenue, POBox 278, North East, MD 21901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

North East Methodist Cem.

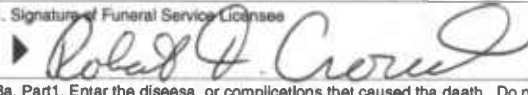
Date

7/8/96

20c. Location - City or Town, State

North East, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, MD 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

2 YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

75 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

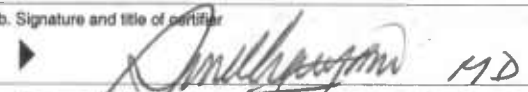
28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 45344

29d. Date signed (Month, Day, Year)

7/5/96

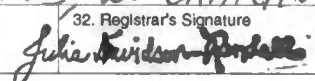
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. DHANJANI, MD 20 CRAIGTOWN RD, PERRYVILLE, MD 21903

31. Date filed (Month, Day, Year)

JUL 08 1996

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21572

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Della Virginia Hagerman</b>				2. Date of Death Month Day Year <b>July 4 1996</b>				3. Time of Death <b>0820 A. M.</b>	
	4e. Facility Name (If not Institution, give street and number) <b>99 Red Hill Road</b>				4b. City, Town, or Location of Death <b>Elkton</b>				4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>236-16-5370</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Feb. 27, 1913</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		Usual Residence of Decedent		10e. State <b>Maryland</b>		10b. County <b>Cecil</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Elkton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>99 Red Hill Road</b>		10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Restaurant</b>		17. Father's Name (First, Middle, Last) <b>John Harvey Honaker</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Surilda Keen</b>		19a. Informant's Name/Relationship (Type, Print) <b>Jerry E. Hagerman</b>	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>595 Blue Ball Road, Elkton, Maryland 21921</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Essaw Rife Cemetery</b>		Date <b>July 9 1996</b>		20c. Location - City or Town, State <b>Keen Mountain, Virginia</b>	
	21. Signature of Funeral Service Licensee <b>Donald S. Hicks</b>		22. Name and Address of Facility <b>Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, Maryland 21921</b>		23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>Coronary artery disease.</b> Due to (or as a consequence of): b. <b>Ischemic cardiomyopathy.</b> Due to (or as a consequence of): c. <b>COPD</b> Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death			
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Jose M. W. High St.</b>		29c. License number <b>D44716</b>	
	29d. Date signed (Month, Day, Year) <b>7-5-96</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jose M. W. High St. Elkton MD.</b>		31. Date filed (Month, Day, Year) <b>JUL 08 1996</b>		32. Registrar's Signature <b>John Davidson-Randall</b>		State Registrar	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



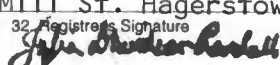
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21573

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nettie Mae Howell</b>				2. Date of Death Month Day Year <b>July 6, 1996</b>		3. Time of Death <b>3:10 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Avalon Manor Home Inc.</b>				4b. City, Town, or Location of Death <b>Hagerstown</b>		4c. County of Death <b>Washington</b>		
Funeral Director	5. Social Security Number <b>212-74-5241</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sep. 19, 1906</b>		
	9. Birthplace (State or Foreign Country) <b>Virginia</b>								
To Be Completed by Funeral Director	Usual Residence of Decedent								
	10a. State <b>MD</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hagerstown</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>20816 Leiters Mill Rd.</b>				10f. Zip Code <b>21742</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Home</b>				
	17. Father's Name (First, Middle, Last) <b>John William Brown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Rosa M</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>David L. Howell</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20816 Leiters Mill Rd. Hagerstown 21742</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenlawn Memorial Park</b>		20c. Location - City or Town, State <b>Williamsport, MD 21795</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>OSBORNE FUNERAL HOME P.O. Box # 348 Williamsport, MD 21795</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Pneumonia</b> Due to (or as a consequence of):								1 month
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of):								
	<b>c.</b> Due to (or as a consequence of):								
	<b>d.</b>								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Heart Disease Arteriosclerosis</b> <b>Cardiomyopathy Diabetes Parkinson Disease</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospitals: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	29b. Signature and title of certifier 				29c. License number <b>D18019</b>		29d. Date signed (Month, Day, Year) <b>July 6, 1996</b>		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Vasant Datta, MD 334 Mill St. Hagerstown, MD 21740</b>								
	31. Date filed (Month, Day, Year) <b>JUL 08 1996</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.



96 21574

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNA EMILY HAMILTON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JULY 8, 1996</b>   |  | 3. TIME OF DEATH<br><b>06:00AM M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-03-0212A</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07/03/1905</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9. COUNTY OF DEATH<br><b>WICOMICO</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>WATERVIEW HEALTHCARE CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>WICOMICO</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SALISBURY</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>105 TIMES SQUARE 109W</b>   |  |  |  | 10f. ZIP CODE<br><b>21802</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>7</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE WILLING</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANNIE E. TODD</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY LOU HAMILTON</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>NUTTERS LANE, PRINCESS ANNE, MD. 21853</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BEECHWOOD CEMETERY</b>   |  | DATE<br><b>7/10</b>   |  | 20c. LOCATION — City or Town, State<br><b>PRINCESS ANNE, MD.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> <b>MO0295</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HINMAN FUNERAL HOME</b><br><b>11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. COPD CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  | Approximate interval Between Onset and Death<br><b>2 days</b>   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D32014</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/8/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MAHESH MOONDRAL SYTE RIVERVIEW DRIVE SALISBURY MD 21801</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 9 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21575

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |  |  |  |
|---|---|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Sandra K Hanekamp   |  |   |  | 2. Date of Death<br>Month Day Year<br>June 22 1996  |  |  |  | 3. Time of Death<br>8:44AM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Memorial Hospital   |  |   |  | 4b. City, Town, or Location of Death<br>Cumberland  |  |  |  | 4c. County of Death<br>Allegany  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>212-38-5925  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>53 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Jan 1 1943                                    |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent   |  |   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Georgia   |  | 10b. County<br>DeKalb   |  | 10c. City, Town or Location<br>Conley   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>3923 Rocky Valley Drive   |  |   |  | 10f. Zip Code<br>30027  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Unknown   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                |  |   |  | 16b. Kind of Business/Industry<br>Home   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Carlton J. Godwin  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia McCullough  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>William E. Hanekamp/husb.   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3923 Rocky Valley Dr.-Conley, GA 30027   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fairview Meml. Gardens  |  | Date<br>6/26/96   |  | 20c. Location - City or Town, State<br>Stockbridge, GA                               |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>S. Mark Smith  |  |   |  | 22. Name and Address of Facility<br>George-Upchurch Funeral Home, PA<br>202 Greene St. Cumb., MD 21502  |  |  |  |  |  |
|   | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Acute myocardial infarction<br>Due to (or as a consequence of):<br>Arteriosclerotic heart disease<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Diabetes<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |   |  |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>Approximate Interval Between Onset and Death<br>7 hours   |  |   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension/ hypothyroidism/ obesity   |  |   |  |   |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |   |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |   |  |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>Dpty Med Ex  |  |   |  | 29c. License number<br>D 09157  |  | 29d. Date signed (Month, Day, Year)<br>June 22 1996                                  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Paul Snow, M.D. 124 w 3rd st Cumb MD 21502  |  |   |  |   |  |  |  |  |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br>JUL 03 1996  |  |   |  | 32. Registrar's Signature<br>John A. Buckner  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21576

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Calvin Hood, III

2. Date of Death  
Month Day Year

6 28 96

3. Time of Death

11 41 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

220-66-9734

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 18, 1957

9. Birthplace (State or Foreign Country)

OKLAHOMA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

GERMANTOWN

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

19706 CRYSTAL ROCK DRIVE, #22

10f. Zip Code

20874

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SERVICE SPECIALIST

16b. Kind of Business/Industry

DURON PAINTS AND WALL COVERINGS

17. Father's Name (First, Middle, Last)

JOHN CALVIN HOOD, JR.

18. Mother's Name (First, Middle, Maiden Surname)

CLADYS MORELAND

19e. Informant's Name/Relationship (Type, Print)

LISA (MOORE) HOOD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19706 CRYSTAL ROCK DR., #22, GERMANTOWN, MD 20874

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TRESTLAWN MEML. GARDENS 7-396

Date

20c. Location - City or Town, State

LA VALE, MD

21. Signature of Funeral Service Licensee

► *Henry P. Upchurch*

22. Name and Address of Facility

GEORGE-UPCHURCH FUNERAL HOME, P.A.  
202 GREENE ST., CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

diabetes

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

6 weeks

20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► *[Signature]* MD

29c. License number

D35703

29d. Date signed (Month, Day, Year)

June 28, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen Vaccarezza 6240 Montrose Rd Rockville MD

31. Date filed (Month, Day, Year)

JUL 03 1996

32. Registrar's Signature

*[Signature]*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21577  
Certificate of Death

Reg. No.

Amended #20c, 7/8/96,  
DHS, Allegany County

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT L. HALL</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>July 1, 1996</b>  |  | 3. Time of Death<br><b>6:15 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |  | 4c. County of Death<br><b>Allegany</b>   |  |
| 5. Social Security Number<br><b>199-20-3383</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 5, 1927</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>ALLEGANY</b>   |  | 10c. City, Town or Location<br><b>CUMBERLAND</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>11606 BIRCH AVENUE</b>   |  | 10f. Zip Code<br><b>21502</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>W.W.II</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CHIEF TRAIN DISPATCHER</b>  |  | 16b. Kind of Business/Industry<br><b>RAILROAD</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ELMER S. HALL</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>GLADYS C. HYATT</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>EVA JEAN HALL</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11606 BIRCH AVENUE-CUMBERLAND, MD 21502</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RESTLAWN MEML. GARDENS</b>   |  | Data<br><b>7-3-96</b>  |  | 20c. Location - City or Town, State<br><b>CUMBERLAND, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>GEORGE-UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>CEREBROVASCULAR ACCIDENT</b><br>a. Due to (or as a consequence of):<br><b>ADVANCED CARCINOMA OF PROSTATE</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>3 days</b><br><b>11/1990</b> |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br> MD   |  | 29c. License number<br><b>D 23371</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 8 1996</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Q. Zaman, Johnson Heights Medical Bldg., Cumberland, MD 21502</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |

State  
Registrar





96 21578

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES PAUL HINEA</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>JULY</b> DAY <b>05</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>06:30 a.m.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-05-5389</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug 19, 1911</b>                                      |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LIONS MANOR NURSING HOME</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>  |  | 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>  |   |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Allegany</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>317 Magruder Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21502</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Ballistics</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John L. Hinea</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Loretto (Newnam)</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy Hinea</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>317 Magruder Street; Cumberland, MD 21502</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SS Peter Paul Cemetery</b>  |  | DATE<br><b>07/09</b>  |  | 20c. LOCATION — City or Town, State<br><b>Cumberland, MD</b>                                    |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James F. Scarpelli</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart failure</b><br>DUE TO (OR AS A CONSEQUENCE OF)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate interval between Onset and Death<br><b>2 months</b>                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive pulmonary disease</b>  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Sunil Gupta</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D33280</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 7, 1996</b>                                      |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>Dr. Sunil Gupta; 625 Kent Avenue; Cumberland, MD 21502</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 09 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Randall</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21579

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JESSIE MAE JONES</b>   |  | 2. Date of Death<br>Month <b>June</b> Day <b>24</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>9:50 PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SALISBURY CENTER: GENESIS ELDERCARE</b>  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY, MD.</b>  |   | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-42-2328</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>MAY 27, 1917</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>LaGRANDE, N.C.</b>  |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |  |   |  |
|   | 10a. State<br><b>MD.</b>  | 10b. County<br><b>WICOMICO</b>   | 10c. City, Town or Location<br><b>SALISBURY</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>SALISBURY CENTER; GENESIS ELDERCARE</b>  |  | 10f. Zip Code<br><b>21801</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:      |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)                           |   |  |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DOMESTIC</b>   |  | 16b. Kind of Business/Industry<br><b>NONE</b>  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JESSE DAVIS</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CLEMMIE PARKS</b>  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>EMMA DAVIS</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1012 FAIRGROUND DRIVE #8: SALISBURY, MD. 21801</b> |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREEN ACRES MEMORY PARK</b>   |   | 20c. Location - City or Town, State<br><b>WEST RD. SALISBURY, MD.</b>  |
|   | 21. Signature of Funeral Service Licensee<br><i>Louisa B. Jolley</i>  |  | 22. Name and Address of Facility<br><b>JOLLEY MEMORIAL CHAPEL,<br/>1213 JERSEY ROAD: SALISBURY, MD. 21801</b>  |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pneumonia And Gastrointestinal Bleed</b><br>Due to (or as a consequence of):        |  |  |   | Approximate Interval Between Onset and Death<br><b>1 Day</b>   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Advanced Dementia</b><br><b>CHF</b><br><b>Diabetes</b><br><b>Aspirin</b><br><b>Schistos</b>                                |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |   |  |
| To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Michael Atkins</i>  |   | 29c. License number<br><b>D-39813</b>                                      |  | 29d. Date signed (Month, Day, Year)<br><b>6/25/96</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804</b>   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 28 1996</b>   |   | 32. Registrar's Signature<br><i>Julia Davidson Randall</i>                 |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |                                |  |  |
|--|--|--|---|---|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ruby H. Justice  |  |  |   | 2. DATE OF DEATH<br>MONTH 07 DAY 02 YEAR 96   |                                | 3. TIME OF DEATH<br>5:15 a.m.  |  |
| 4. SOCIAL SECURITY NUMBER<br>240-38-2339   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>70 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Dec. 7, 1925   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>No. Carolina   |  |  |   | 9a. FACILITY NAME (If not institution, give street and number)<br>Deer's Head Center  |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Salisbury   |  |
| 9c. COUNTY OF DEATH<br>Wicomico  |  |  |   | 10a. STATE<br>Md.   |                                | 10b. COUNTY<br>Wicomico  |  |
| 10c. CITY, TOWN OR LOCATION<br>Salisbury   |  |  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |                                | 10e. STREET AND NUMBER<br>807 Gettysburg Ave.  |  |
| 10f. ZIP CODE<br>21801   |  |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10  |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Cafeteria Worker   |                                | 16b. KIND OF BUSINESS/INDUSTRY<br>Food Service   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Alvie Hewitt  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Goldie Hewitt  |                                |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Donna Niblett  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>31929 Bon Hill Drive   |                                |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Springhill Memory Gdns. 7/5  |                                | 20c. LOCATION — City or Town, State<br>Hebron, Md.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sealed C. Bounds</i>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Bounds Funeral Home, Salisbury, Md. 21804   |                                |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <u>Pneumonitis</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>possible Pulmonary Embolism</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Approximate interval between Onset and Death<br>2 days<br>2 days |  |  |   |   |                                |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____  |  |  |   |   |                                |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |                                |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |   |   |                                |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |   | 28a. DATE OF INJURY (Month, Day, Year)  |                                | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |   | 28d. DESCRIBE HOW INJURY OCCURRED   |                                |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |                                |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>I. J. Hwang, M.D.</i>  |  |  |   | 29c. LICENSE NUMBER<br>D16003   |                                | 29d. DATE SIGNED (Month, Day, Year)<br>7/2/96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>I. J. Hwang, M.D., PO Box 2018, Salisbury, MD. 21802-2018   |  |  |   |   |                                |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 03 1996   |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson-Randall</i>   |                                |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21581

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BOBBY A. JACKSON

2. Date of Death

Month Day Year  
July 4, 1996

3. Time of Death

8:30 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

215-34-9840

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 9, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Frederick

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4454 Mill Bottom Rd.

10f. Zip Code

21771

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Refuse Company

17. Father's Name (First, Middle, Last)

Charles Herbert Jackson, Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Captoria Gray

19a. Informant's Name/Relationship (Type, Print)

Betty M. Crouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4454 Mill Bottom Rd./ Mt. Airy, Md. 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Friendship U.M. Cem.

Data

7-9-96

20c. Location - City or Town, State

Friendship, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Home

1621 Opossumtown Pike/ Frederick, Md. 21702

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ADENOCARCINOMA OF LUNG

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

023630

29d. Date signed (Month, Day, Year)

07-04-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANK J. MAYO, MD 16220 Frederick RD #213, G. Thierbury, MD 21777

31. Date filed (Month, Day, Year)

JUL 11 1996

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21582

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OLEDA

JENKINS

2. Date of Death

JULY 6 1996 Year

3. Time of Death

06:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5151 ALLENTOWN ROAD RAMADA INN

4b. City, Town, or Location of Death

Camp Springs

4c. County of Death

PRINCE GEORGES

5. Social Security Number

259-54-9218

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 7 1918

9. Birthplace (State or Foreign Country)

GA

Usual Residence of Decedent

10a. State

GA

10b. County

Laurens

10c. City, Town or Location

Dublin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

820 Brewton Lovett Road

10f. Zip Code

31021

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Cebil

Daniel

18. Mother's Name (First, Middle, Maiden Surname)

Ida

19a. Informant's Name/Relationship (Type, Print)

Leon Jenkins, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

206 Felder Street Dublin, GA 31021

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

Date

20c. Location - City or Town, State

Mission Cemetery July 11, 1996 Dublin, GA

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

6633 Old Alex. Ferry Rd

Lee Funeral Home, Inc. Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Arteriosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald G. Wright MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD G. WRIGHT M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 9 1996

32. Registrar's Signature

John Andrew Randall

State Registrar

Baltimore, Maryland 21215-0020

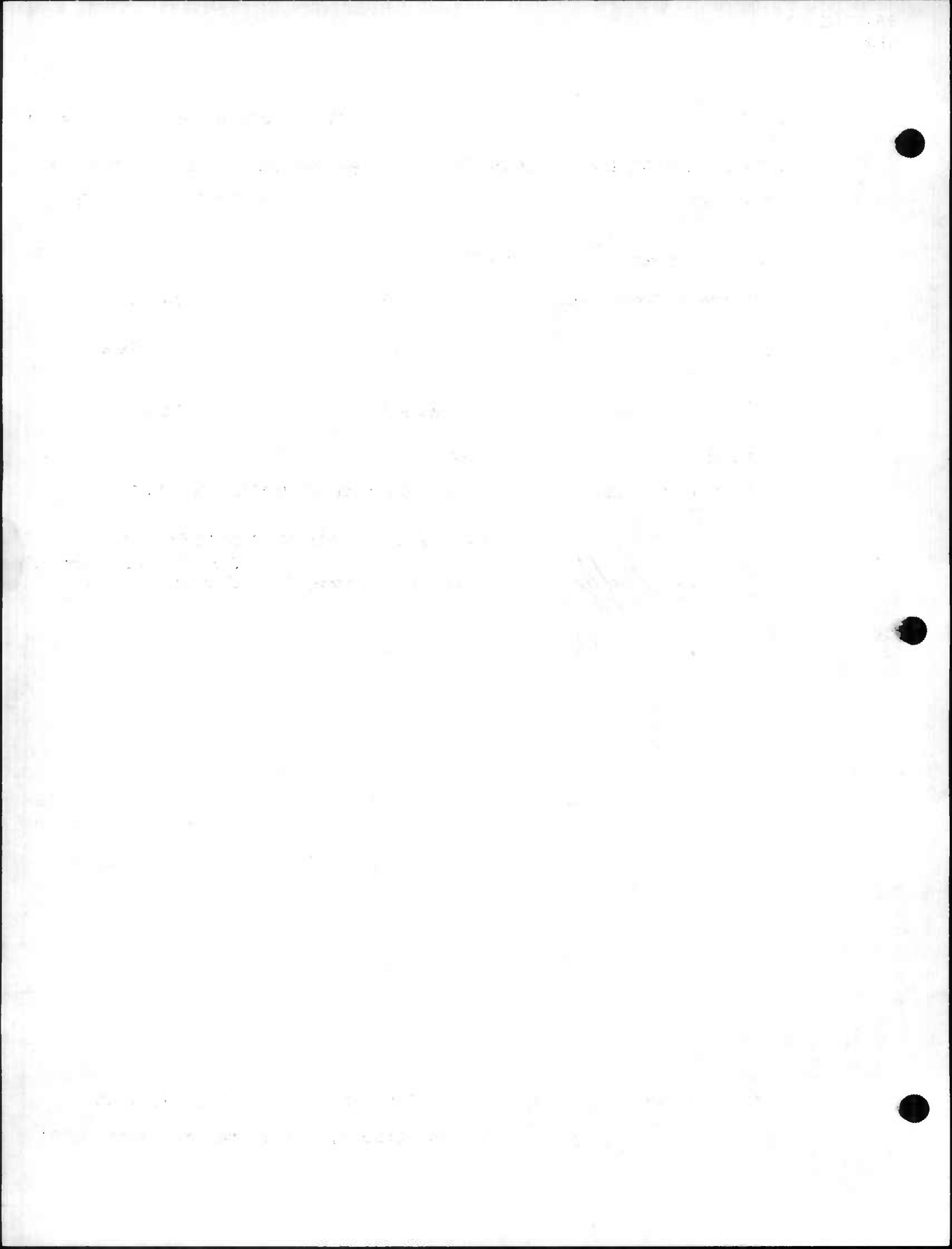
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21583

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Ellsworth

Johnston, Jr.

2. Date of Death

Month  
JulyDay  
7Year  
1996

3. Time of Death

7:15 A:M

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

5. Social Security Number

114-09-2005

6. Sex

1X M 2□ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 6, 1915

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1□ Yes 2X No

10e. Street and Number

5779 Springfish Road

10f. Zip Code

20603

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2□ Married  
3X Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1X Yes 2□ No

If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Corrections Officer

16b. Kind of Business/Industry

Law Enforcement

17. Father's Name (First, Middle, Last)

Robert Ellsworth Johnston

18. Mother's Name (First, Middle, Maiden Surname)

Mary Keenan

19a. Informant's Name/Relationship (Type, Print)

Robert E. Johnston, III/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5779 Springfish Place, Waldorf, MD 20603

20a. Method of Disposition

1□ Burial 2X Cremation 3□ Removal from State  
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Huntt Crematory

Date

July 8, 1996 Waldorf, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Benjamin M. Matthews M-000658

22. Name and Address of Facility

The Huntt Funeral Home, Inc.  
P.O. Box 156, Waldorf, Maryland 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4X Unknown

24a. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2X No

Hospital:

1X Inpatient

2□ ER/Outpatient

3□ DOA

Other:

28. Place of Death (Check only one)

4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1X Natural 5□ Pending investigation  
2□ Accident 6□ Could not be determined  
3□ Suicide  
4□ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

44436

29d. Date signed (Month, Day, Year)

July 7 96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashvinkumar Patel MD 603 Post Office Rd. Suite #207 Waldorf, Md. 20602

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 10 1996

32. Registrar's Signature

[Signature]

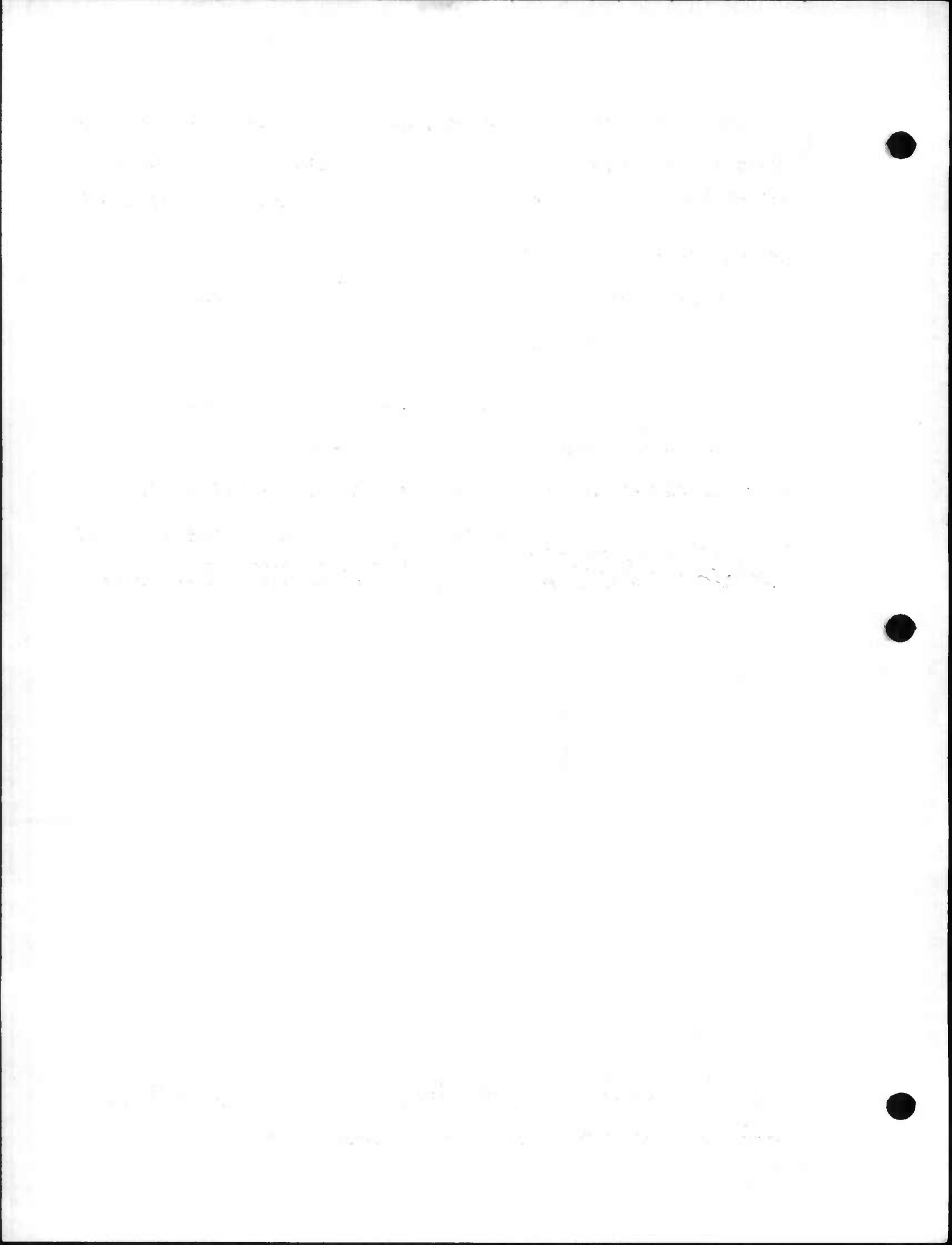
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21584

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Elizabeth JACKSON

2. Date of Death

Month Day Year  
July 08, 1996

3. Time of Death

3:03 pm

4a. Facility Name (If not institution, give street and number)

Ravenwood Lutheran Home

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

213-74-0464

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 5, 1903

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Maugansville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18017 Showalter Road

10f. Zip Code

21767

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

John McPherson Gossard

18. Mother's Name (First, Middle, Maiden Surname)

Mary Rosella Washler

19a. Informant's Name/Relationship (Type, Print)

Patricia M. Branch Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18017 Showalter Road Maugansville, Maryland 21767

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

7/11/96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gerald N. Minnich Funeral Home

305 N. Potomac Street  
Hagerstown, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CARDIAC ARREST

Due to (or as a consequence of):

INSTANT

b. HYPERKALEMIA

Due to (or as a consequence of):

2 WEEKS

c. DEHYDRATION

Due to (or as a consequence of):

2 WEEKS

d. PNEUMONIA

2 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBRAL ATROPHY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

007857

29d. Date signed (Month, Day, Year)

JULY 09, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

EDSON MOODY, MD., 1190 MT. AETNA RD., HAGERSTOWN, MD. 21740

31. Date filed (Month, Day, Year)

JUL 11 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96-3878-037

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

CIP ITEMS: 23 PART I, 27, PER MEO State of Maryland / Department of Health and Mental Hygiene

96 21585

FILM G-737 7/26/96 t.t

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>BREUN DARNELL JEFFERY</b>  |  |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>12</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>10:55 PM</b>   |  |
|   | 4a. Facility Name (If Not Institution, give street and number)<br><b>PATUXENT NAVAL AIR STATION HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>PATUXENT RIVER</b>   |  | 4c. County of Death<br><b>ST. MARY'S</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-47-9352</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>Yrs. <b>5</b> Months <b>2</b>   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 10, 1996</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>Lexington Park</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>Lot #2 Lord Calvert Mobile Home Park</b>   |  | 10f. Zip Code<br><b>20653</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>-0-</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>   |  | 16b. Kind of Business/Industry<br><b>N/A</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Andrew Jeffrey</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Tandra Yolanda Maddox</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Tandra Y. Jeffrey</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Lot #2, Lord Calvert MHP, Lexington Park, MD 20653</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Bushwood, MD</b>  |  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. SUDDEN INFANT DEATH SYNDROME (SIDS)</b><br>Due to (or as a consequence of):<br><br><b>b. Due to (or as a consequence of):</b><br><br><b>c. Due to (or as a consequence of):</b><br><br><b>d. Due to (or as a consequence of):</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  |
|   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>JULY 13, 1996</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>111 Penn Street, Baltimore, Maryland 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>JUL 19 1996</b>   |  | 32. Registrar's Signature<br>  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21586

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |   |   |   |   |   |  |   |  |
|--|---|--|---|--|---|---|---|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Janet E. Jaccard</b>   |  |   |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>5</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>21:40</b>                              |   |   |  |   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Union Hospital</b>   |  |   |  |   | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |   | 4c. County of Death<br><b>Cecil</b>                           |   |   |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>211-20-6372</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>67</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>July 5 1929</b>               |   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                             |   |  |   |  |
|  | Usual Residence of Decedent   |  |   |  |   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Cecil</b>                                   |   | 10c. City, Town or Location<br><b>Chesapeake City</b> |  |   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |   | 10e. Street and Number<br><b>23 Front St.</b>   |   | 10f. Zip Code<br><b>21915</b>                                 |   | 10g. Citizen of What Country?<br><b>USA</b>           |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |   |   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                 |   | 16b. Kind of Business/Industry<br><b>Home</b>                 |   |   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Wade Barron</b>   |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marion Metz</b>   |   |   |   |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert E. Jaccard</b>  |  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23 Front St. Chesapeake City MD 21915</b> |   |   |   |   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R A Ferris</b>   |   | 20c. Location - City or Town, State<br><b>West Chester PA</b> |   | 20d. Date<br><b>July 10 1996</b>                      |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Robert Jaccard</b>  |  |   |  |   | 22. Name and Address of Facility<br><b>R. T. Foard Funeral Home, P.A.<br/>318 George St. Chesapeake City MD 21915</b>                         |   |   |   |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br>b. <b>Seizure Post Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br>c. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>d. <b>Bilateral Coronary Artery Stenosis</b> |  |   |  |   |   |   |   |   |   | Approximate Interval Between Onset and Death<br><b>6 days</b><br><b>5 days</b><br><b>12 years</b><br><b>4 months</b>   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypothyroidism</b>   |  |   |  |   |   |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how Injury occurred  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  | 29b. Signature and title of certifier<br><b>Jayantilal K. Patel MD</b>  |   |   |   |   | 29c. License number<br><b>A 22307</b>                 |  | 29d. Date signed (Month, Day, Year)<br><b>July 8 96</b> |  |
| 30. Name and address of person who completed causa of death (Item 23e) (Type, Print)<br><b>JAYANTILAL K PATEL MD 123 SINGERLY AVE, ELKTON MD 21921</b>   |   |  |   |  |   |   |   |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>  |   |  |   |  | 32. Registrar's Signature<br><b>Juha Davidson-Rodriguez</b>   |   |   |   |   |   |  |   |  |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Name: JACCARD JANET ELIZABETH -  
Physician /Medical Examiner

Physician /Medical Examiner



96 21587

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARYANN RITA JAMES  |  |  |  | 2. DATE OF DEATH<br>MONTH JULY DAY 5, YEAR 1996   |  | 3. TIME OF DEATH<br>2:30 P.M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>182-26-8135  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>60 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>MAY 9, 1936   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>PENNSYLVANIA  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>20211 BENT WILLOW ROAD  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>ROHRERSVILLE  |  |
| 9c. COUNTY OF DEATH<br>WASHINGTON   |  |  |  | 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>WASHINGTON  |  |
| 10c. CITY, TOWN OR LOCATION<br>ROHRERSVILLE   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>20211 BENT WILLOW ROAD   |  |
| 10f. ZIP CODE<br>21779  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN GIAFAGLIONE   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ROSE DESANTO   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>EMANUEL P. JAMES  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>20211 BENT WILLOW ROAD, ROHRERSVILLE, MD 21779   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>ST PETER & PAUL CEM. 7/9/96  |  | 20c. LOCATION — City or Town, State<br>SPRINGFIELD, PA.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Paul M. Dean Paul M. Dean  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>BAST FUNERAL HOME 7606 Old National Pike<br>Boonsboro, MD 21713   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arrhythmia (CARDIAC)</u><br>b. <u>CARDIOMYOPATHY (ISCHEMIC)</u><br>c. <u>ATHEROSCLEROSIS</u><br>d. <u>DIABETES Mellitus</u><br>Approximate Interval Between Onset and Death<br>minutes<br>months<br>years<br>years |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>END STAGE RENAL DISEASE</u>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mark P. Rubin, M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D29592   |  | 29d. DATE SIGNED (Month, Day, Year)<br>7/6/96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>201 Thomas Johnson Drive FREDERICK MD 21702 DR. MARK P. RUBIN  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 08 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Andrew Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21588  
Certificate of Death

Reg. No.

Amended #s 1, 14, 2/9/96,  
Nels, Allegany CountyPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Theresa ~~THRESA~~ V. JOHNSON

2. Date of Death

Month Day Year  
July 3, 1996

3. Time of Death

7:31 am

4a. Facility Name (If not institution, give street and number)

Memorial Hospital &amp; Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

203-28-3618

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 12, 1931

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Piedmont

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street end Number

51 Jones Street

10f. Zip Code

26750

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

Douglas I. Twyman

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Jane (Brown)

19a. Informant's Name/Relationship (Type, Print)

Lilly McCray

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

51 Jones Street; Piedmont, WV 26750

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Potomac Memorial Gardens

Date

07/06

20c. Location - City or Town, State

Keyser, WV

21. Signature of Funeral Service Licensee

Wm A. Fredlock

22. Name and Address of Facility

Fredlock Funeral Home  
Piedmont, WV 26750

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

Ten Days

b. Bilateral leg Ulcers (Necrotic)

Due to (or as a consequence of):

3 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure, Hypertension, Subclavian Venous

Thrombosis.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. A. Ranjithan

29c. License number

D 19318

29d. Date signed (Month, Day, Year)

July 3rd 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ranjithan- 517 Oldtown Road- Cumberland, MD 21502

31. Date filed (Month, Day, Year)

JUL 09 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 21589

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Elizabeth L. Jacobs   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 09 1996  |  | 3. TIME OF DEATH<br>8:25AM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>218 60 1948  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>89 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>MAY 18, 1907                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>FROSTBURG VILLAGE NURSING HOME  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FROSTBURG                                     |  |
| 9c. COUNTY OF DEATH<br>ALLEGANY   |  |   |  | 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>ALLEGANY  |  |
| 10c. CITY, TOWN OR LOCATION<br>FROSTBURG  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>98 W. COLLEGE AVENUE                                       |  |
| 10f. ZIP CODE<br>21532  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)<br>4  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>THOMAS LOVE  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ELIZABETH PICKEN   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>RUTH HUTCHESON / DAUGHTER   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>105 E. RING FACTORY ROAD, BEL AIR, MD 21014  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>FROSTBURG MEMORIAL PARK 7/12/96  |  | 20c. LOCATION — City or Town, State<br>FROSTBURG, MD 21532  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Monica M. Sowers</i>                 |  |
| 22. NAME AND ADDRESS OF FACILITY<br>SOWERS FUNERAL HOME, P.A.<br>60 W. MAIN ST., FROSTBURG, MD 21532  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal failure</i><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <i>arteriosclerosis</i><br>b.<br>c.<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Breza M.D.</i>   |  | 29c. LICENSE NUMBER<br>D12532   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8-9-96   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>GEORGE M. BREZA, M.D., 912 SETON DRIVE, CUMBERLAND, MD 21502   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 11 1996  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Breza</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21590

Reg. No.

|   |  |   |   |  |  |   |   |  |  |
|---|--|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Harold William Kefauver</b>   |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>2</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>4:05 P. M.</b>                                   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>100 Broad St.</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Middletown</b>  |   | 4c. County of Death<br><b>Frederick</b>                                 |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>224-60-2941</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 6, 1907</b>              | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>   |  |
|   | Usual Residence of Decedent  |   |   |  |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>   | 10b. County<br><b>Frederick</b>   | 10c. City, Town or Location<br><b>Middletown</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |   |  |  |
|   | 10e. Street and Number<br><b>100 Broad St.</b>   |   |   | 10f. Zip Code<br><b>21769</b>                    |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>fiscal agent</b>                  |  |  | 16b. Kind of Business/Industry<br><b>federal gov't.</b>   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William J. Kefauver</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Delauter</b>  |   |   |  |  |
| Physician<br>/Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth H. Kefauver (Wife)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>100 Broad St., Middletown, Md. 21769</b>   |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Reformed Cemetery</b>  |  | Date<br><b>7/7</b>   |   | 20c. Location - City or Town, State<br><b>Middletown, Md.</b>           |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Donald B. Thompson Funeral Home<br/>31 E. Main St., Middletown, Md. 21769</b>                              |  |  |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pneumonia</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |   |   |  |  |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D16939</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>7/7/96</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Behno Middletown, MD</b>   |  |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>   |  | 32. Registrar's Signature<br>   |   |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21591

DHHM 16 Rev 6/95

**Baltimore, Maryland 21215-0020**

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**



96 21592

Rev 6/95

**Division of Vital Records, P.O. Box 68760,**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To Be Completed by Funeral Director**

**Medical Certification: To Be Completed by Physician/Medical Examiner**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21593

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |  |   |  |  |
|--|--|---|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WALTER CHARLES KEYSER</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>July 4, 1996</b>  |  | 3. Time of Death<br><b>11:55 AM</b>                                     |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |  | 4c. County of Death<br><b>Allegany</b>                                  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>705-07-9580</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jun 16, 1908</b>              |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |   | 10a. State<br><b>WV</b>   |   | 10b. County<br><b>Hampshire</b>  |  | 10c. City, Town or Location<br><b>Greenspring</b>                       |  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>P.O. Box 64</b>  |   | 10f. Zip Code<br><b>26722</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retired</b>                       |   | 16b. Kind of Business/Industry<br><b>B &amp; O Railroad</b>  |  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Walter Kaiser</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian (Lang)</b>   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Walter W. Kaiser--son</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 97; Greenspring, WV 26722</b>   |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park</b>   |   | 20c. Date<br><b>07/08</b>  |  | 20d. Location - City or Town, State<br><b>Cumberland, MD</b>            |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Nicholas J. Scarpelli</i>  |   |   |   | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Coronary artery disease</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |   |  |  |   | Approximate Interval Between Onset and Death<br><b>5 years</b>   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)                     |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>S. Gupta</i>  |   | 29c. License number<br><b>D 33280</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 5, 1996</b> |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. S. Gupta Johnson Heights Medical Bldg. Cumberland, MD 21502</b>   |  |   |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 1996</b>  |  | 32. Registrar's Signature<br><i>John Davidson Randall</i>   |   |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social development.

4. The fourth part of the report deals with the political situation of the country. It is a very interesting and informative study of the country's political development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's political development.

5. The fifth part of the report deals with the cultural situation of the country. It is a very interesting and informative study of the country's cultural development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's cultural development.



96 21594

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GRACE LAVADA KERNS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>JULY</b> DAY <b>06</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>06:20 a.m.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-14-7016</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APRIL 14 1916</b>   |  |
| 8a. FACILITY NAME (If not Institution, give street and number)<br><b>LIONS MANOR NURSING HOME</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>  |  | 8c. COUNTY OF DEATH<br><b>ALLEGANY</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>ALLEGANY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>CUMBERLAND</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>11111 LOCUST GROVE ROAD N.W.</b>  |  |  |  | 10f. ZIP CODE<br><b>21502</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>10</b> College (1-4 or 5+) <b>10</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ALLEGANY CO BOARD OF EDUCATION CUSTODIAN IN SCHOOL</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHRISTOPHER COLUMBUS GARLICK</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ETHEL NORA O'NEAL</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CAROLYN MARTZ NIECE</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14303 WINCHESTER ROAD CUMBERLAND MD. 21502</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>REST LAWN CEMETERY JULY 8 1996</b>   |  | 20c. LOCATION — City or Town, State<br><b>LAVALLE MARYLAND</b>  |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Dale L. Merritt</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MERRITT-ADAMS FUNERAL HOME<br/>404 DECATUR STREET CUMBERLAND MARYLAND</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Acute C.H.F.</b>   |  |   |  |   |  |
|  |  | b. <b>Endstage C.A.D.</b>  |  |   |  |   |  |
|  |  | c. _____   |  |   |  |   |  |
|  |  | d. _____   |  |   |  |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diab. Mellitus, S/P Coronary artery bypass.</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>V.A. Ranjithan V.A. Ranjithan</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D19750</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 8th 96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>V.A. Ranjithan, M.D., Lions Manor Nursing Home, Seton Dr. Ext., Cumberland, MD 21502</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 08 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jane [Signature]</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21595

Reg. No.

|   |  |  |  |  |   |  |  |  |
|---|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ELEANOR JANE KENNEY</b>                     |  |  |  | 2. Date of Death<br>Month Day Year<br><b>July 7, 1996</b> |  | 3. Time of Death<br><b>6:05 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b> |  | 4c. County of Death<br><b>Allegany</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-20-6754</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 23, 1926</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                              |
|   | Usual Residence of Decedent  |  |  |  |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>ALLEGANY</b>   |  | 10c. City, Town or Location<br><b>CUMBERLAND</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>212 S. ALLEGANY STREET</b>   |  |  |  | 10f. Zip Code<br><b>21502</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CHECKER</b>  |   | 16b. Kind of Business/Industry<br><b>CUMBERLAND LAUNDRY</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>CHARLES REYNARD</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNE LOWERY</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JOSEPH C. KENNEY</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>212 S. ALLEGANY ST. - CUMBERLAND, MD 21502</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MSVC-ROCKY GAP</b>  |  | Data<br><b>7-11-96</b>   |   | 20c. Location - City or Town, State<br><b>FLINTSTONE, MD</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Wanda A. Upchurch</i>   |  |  |  | 22. Name and Address of Facility<br><b>GEORGE-UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>ANOXIC ENCEPHALOPATHY</b><br>Due to (or as a consequence of):<br><br>b. <b>ASPIRATION</b><br>Due to (or as a consequence of):<br><br>c. <b>CEREBROVASCULAR ACCIDENT</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><br>10 days<br><br>10 days<br><br>1 year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Chronic Lung Disease</b><br><br><b>Coronary Heart Disease</b>  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner   |  | 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Dr. D. Shah</i>   |  | 29c. License number<br><b>D 23334</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 8, 1996</b>   |   |  |  |  |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><b>Dr. D. Shah, Johnson Heights Medical Bldg., Cumberland, MD 21502</b>   |  |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 8 1996</b>  |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>  |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



96 21596

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Louise V. Kile   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 8 1996  |  |   |  | 3. TIME OF DEATH<br>12:15 A. M   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-64-8801   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>77 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept 10 1918 |  | 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>24105 Pine Hill Road, S.W.   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rawlings  |  |   |  | 9c. COUNTY OF DEATH<br>Allegany  |  |  |  |
| 10a. STATE<br>MD   |  |  |  | 10b. COUNTY<br>Allegany  |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Rawlings  |  |  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>24105 Pine Hill Road, S.W.   |  |   |  | 10f. ZIP CODE<br>21557   |  |  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (14 or 8+) 10   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  |   |  | 17. FATHER'S NAME (First, Middle, Last)<br>William F. Junkins  |  |  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Victoria S. Rush  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br>Ona M. Kile, Jr.   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12210 Bridgeport Road Taneytown, MD 21787   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Dawson Cemetery July 10 1996  |  |   |  | 20c. LOCATION — City or Town, State<br>Rawlings, MD 21557  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Rotruck-Smith Funeral Home<br>85 South Main Street Keyser, WV 26726  |  |   |  | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Diabetes mellitus</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate interval Between Onset and Death<br><i>20 yrs</i> |  |  |  |
| 24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Coronary Artery Disease</i>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>10277</i>  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><i>7/9/96</i>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>W. Guy Fiscus, M.D. 500 Memorial Avenue Cumberland, MD 21502                                    |  |   |  | 31. DATE FILED (Month, Day, Year)<br>JUL 10 1996   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |  |  |   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


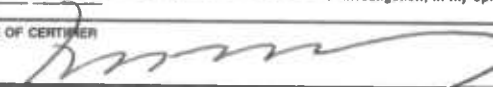
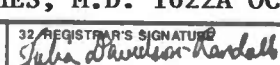
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 21597

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FULTON J. LYNCH</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>JUNE</b> DAY <b>26</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>2:10 P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>222-14-4495</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APR. 7, 1911</b>                                      |   |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>BERLIN NURSING &amp; REHABILITATION CTR.</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BERLIN</b>  |  | 9c. COUNTY OF DEATH<br><b>WORCESTER</b>   |   |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |   |
| 10a. STATE<br><b>DELAWARE</b>  |  | 10b. COUNTY<br><b>SUSSEX</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>SELBYVILLE</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>8 McCABE STREET</b>   |  |   |  | 10f. ZIP CODE<br><b>19975</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HATCHERYMAN</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>POULTRY</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ARCHIE G. LYNCH</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CLEORA DONOWAY</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MADLINE B. LYNCH</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8 McCABE STREET, SELBYVILLE, DELAWARE 19975</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BISHOPVILLE CEMETERY 6/30/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>BISHOPVILLE, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Conjunctive Heart Failure</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>1. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>2. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>3. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>4. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>17y</b><br><b>7y</b>                               |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PVD - Gangrene bilateral.</b><br><b>Renal Failure</b>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  | 29c. LICENSE NUMBER<br><b>D02026</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>6/27/96</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FEDERICO G. ARTHE, M.D. 1622A OCEAN PINES BERLIN MD 21811</b>  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JUN 28 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21598

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD R LUSBY

2. Date of Death

Month

Day

Year

July

5

1996

3. Time of Death

2:25pm

4a. Facility Name (If not institution, give street and number)

North Arundel Convalescent Center

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

212-16-2031

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

9 1

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10/4/1903

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Hospital Drive

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12+

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Manager

18b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Charles S. Lusby

18. Mother's Name (First, Middle, Maiden Surname)

Sara Dixon

19a. Informant's Name/Relationship (Type, Print)

Elvira Joy/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

722 Cypress Rd. Severna Park MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Olivet Cemetery

Date

7/9/96

20c. Location - City or Town, State

Olivet, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco and Sons Funeral Home

495 Ritchie Hwy Severna Park MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Arteriosclerotic Cardiovascular Disease Twenty Years

Due to (or as a consequence of):

b. Multi Infarct dementia.

Due to (or as a consequence of):

c. Recurrent Pneumonia.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Non Insulin dependent diabetes

mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44973

29d. Date signed (Month, Day, Year)

7/8/1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GURMEET S. SAWHNEY MD, 202 HOSPITAL DRIVE, 325, GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year)

JUL 12 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21599

|   |  |   |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|---|--|---|--|--|--|---|--|--|---|-------------------------------------|---|--|---------------------------------------|---------------|------------------------------------|---------------|------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>George F. LOWE</i>  |   |  |  | 2. Date of Death<br>Month <i>July</i> Day <i>2</i> Year <i>1996</i>  |   | 3. Time of Death<br><i>5:00P</i>   |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | 4e. Facility Name (If not institution, give street and number)<br><i>Doctor's Community Hospital</i>   |   |  |  | 4b. City, Town, or Location of Death<br><i>Lanham</i>  |   | 4c. County of Death<br><i>Prince George's</i>  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| Funeral<br>Director   | 5. Social Security Number<br><i>578-03-2464</i>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><i>82</i> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><i>Oct 7, 1913</i>   | 9. Birthplace (State or Foreign Country)<br><i>Washington DC</i> |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | Usual Residence of Decedent  |   |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| To Be Completed by Funeral Director   | 10a. State<br><i>W. Virginia</i>   |   | 10b. County<br><i>Jefferson</i>  |  | 10c. City, Town or Location<br><i>Charles Town</i>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | 10e. Street and Number<br><i>187 Tusawilla Hills</i>   |   |  |  | 10f. Zip Code<br><i>25414</i>  |   | 10g. Citizen of What Country?<br><i>United States</i>  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>1942-1946</i> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>White</i> |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><i>8th</i>  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Engineer</i>   |   | 16b. Kind of Business/Industry<br><i>D.C. Dept of Schools</i>  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | 17. Father's Name (First, Middle, Last)<br><i>Charles Stein Lowe</i>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mary Loretta Cox</i>   |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Mary Loretta Robison</i>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>187 Tusawilla Hills, Charles Town, W. Virginia 25414</i>   |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Cedar Hill Cemetery</i>   |   | 20c. Location - City or Town, State<br><i>Suitland, Maryland</i>   |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | 21. Signature of Funeral Service Licensee<br><i>Charles L. Belanger</i>  |   |  |  | 22. Name and Address of Facility<br><i>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735</i>   |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Acute respiratory failure</i></td> <td>Approximate Interval Between Onset and Death<br/><i>8 days</i></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <i>Acute myocardial infarction</i></td> <td><i>8 days</i></td> </tr> <tr> <td>c. <i>Congestive heart failure</i></td> <td><i>8 days</i></td> </tr> <tr> <td>d. <i>Prostate carcinoma</i></td> <td><i>2 years</i></td> </tr> </table> |   |  |  |  |   |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <i>Acute respiratory failure</i> | Approximate Interval Between Onset and Death<br><i>8 days</i> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <i>Acute myocardial infarction</i> | <i>8 days</i> | c. <i>Congestive heart failure</i> | <i>8 days</i> | d. <i>Prostate carcinoma</i> |
| Immediate Cause (Final disease or condition resulting in death)   | a. <i>Acute respiratory failure</i>  | Approximate Interval Between Onset and Death<br><i>8 days</i>   |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. <i>Acute myocardial infarction</i>  | <i>8 days</i>   |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | c. <i>Congestive heart failure</i>   | <i>8 days</i>   |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | d. <i>Prostate carcinoma</i>   | <i>2 years</i>  |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Papillary transitional cell carcinoma bladder newly diagnosed</i><br><i>hypertension</i>  |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><i>M</i>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred                |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| 29b. Signature and title of certifier<br><i>Alan G. Champaloux MD</i>   |  |   |  | 29c. License number<br><i>504249</i>             |  | 29d. Date signed (Month, Day, Year)<br><i>7/3/1996</i>                                      |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Alan G. CHAMPALOUX MD. Upper Marlboro Md 20778</i>   |  |   |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |
| 31. Date filed (Month, Day, Year)<br><i>JUL 09 1996</i>   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |  |   |                                     |   |  |                                       |               |                                    |               |                              |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21600

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Esta Irene LANTZ

2. Date of Death

Month Day Year  
July 10, 1996

3. Time of Death

9:40 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Homewood Retirement Center

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

5. Social Security Number

212-10-0073

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 3, 1894

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

414 Mitchell Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)  
operator

16b. Kind of Business/Industry

telephone company

17. Father's Name (First, Middle, Last)

Daniel T. Lantz

18. Mother's Name (First, Middle, Maiden Surname)

Annie I. Miller

19a. Informant's Name/Relationship (Type, Print)

Hazel Lantz

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18021 Putter Drive, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rest Haven Cemetery

Date

7-13-96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

15 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION OF Mucus Plug

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. INABILITY TO CLEAR SECRETIONS

Due to (or as a consequence of):

Months

c. GENERALIZED WEAKNESS

Due to (or as a consequence of):

Years

d. PATHEMATOIDS ANTIPOIDS

Decades

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D1700

29d. Date signed (Month, Day, Year)

7/11/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN E. METZNER, MD 747 Northern Ave. Hagerstown, MD

31. Date filed (Month, Day, Year)

JUL 12 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 21601

Reg. No.

|  |  |  |   |   |  |  |  |  |
|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner      | 1. Decedent's Name (First, Middle, Last)<br>Gerald Lee LONG, Sr.   |  |   |   | 2. Date of Death<br>Month Day Year<br>July 8, 1996   |  | 3. Time of Death<br>5:50 PM  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br>Washington County Hospital   |  |   |   | 4b. City, Town, or Location of Death<br>Hagerstown   |  | 4c. County of Death<br>WASHINGTON  |  |
| Funeral<br>Director                    | 5. Social Security Number<br>213-24-7557   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>66 Yrs. | 8. Date of Birth (Month, Day, Year)<br>Oct. 16, 1929   |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent  |  |   |   |  |  |  |  |
| To Be Completed by<br>Funeral Director | 10e. State<br>MD   |  | 10b. County<br>Washington   |   | 10c. City, Town or Location<br>Sharpsburg  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 10e. Street and Number<br>17800 Millers Sawmill Rd.  |  |   |   | 10f. Zip Code<br>21782   |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |  | College (1-4 or 5+)   |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Underground Foreman   |  | 16b. Kind of Business/Industry<br>Electric Power   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Merle D. Long   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elta Faye Spong   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Sandra M. Long   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>17800 Millers Sawmill Rd. Sharpsburg, MD 21782  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. View Cemetery   |   | Date<br>July 11, 1996  |  | 20c. Location - City or Town, State<br>Sharpsburg, MD 21782  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>OSBORNE FUNERAL HOME<br>P.O. Box # 348 Williamsport, MD 21795  |  |  |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Multi Organ Failure<br>Due to (or as a consequence of):<br>b. SEPSIS<br>Due to (or as a consequence of):<br>c. POSTSURGICAL COMPLICATION OF ESOPHAGECTOMY<br>Due to (or as a consequence of):<br>d. ESOPHAGEAL CANCER |  |   |   |  |  |  |  |
|  | Approximate Interval Between Onset and Death<br>1 WK<br>2 WK<br>2 WK<br>2 mo   |  |   |   |  |  |  |  |
| Physician<br>/Medical<br>Examiner      | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ATHRO SCLEROTIC VASCULAR DISEASE   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how Injury occurred  |  |  |  |
|  |  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |  |  |
|  | 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br>D44996  |  | 29d. Date signed (Month, Day, Year)<br>JULY 8, 1996.   |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>ZAFAR MOJIK 20311 LAPPANS RD DOONS BORO MD 21713   |  |   |   |  |  |  |  |
| State<br>Registrar                     | 31. Date filed (Month, Day, Year)<br>JUL 09 1996   |  |   |   | 32. Registrar's Signature<br>   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

3. The third part of the document addresses the role of the accounting department in the overall management of the organization. It highlights the department's responsibility for providing accurate and timely financial information to management and for ensuring that all transactions are properly recorded and reported.

4. The fourth part of the document discusses the importance of internal controls in the accounting process. It explains how internal controls help to ensure the accuracy and reliability of financial data and to prevent errors and fraud.

5. The fifth part of the document provides a summary of the key points discussed in the document. It reiterates the importance of accurate record-keeping, proper procedures, and internal controls in the accounting process.

— 150 —



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State of Maryland / Department of Health and Mental Hygiene

96 21602

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Blanche Menota LYNCH                             |  |  |  |   |  | 2. Date of Death<br>Month <u>July</u> Day <u>7</u> Year <u>96</u> |  | 3. Time of Death<br><u>1330</u>           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital |  |  |  |   |  | 4b. City, Town, or Location of Death<br>Hagerstown                |  | 4c. County of Death<br>Washington         |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-16-1612   |  | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>86 Yrs. |  | If Under 1 Year<br>Months Days                                    |  | If Under 24 Hrs.<br>Hours Min.            |  |
|   | 6. Date of Birth (Month, Day, Year)<br>Feb. 6 1910   |  | 9. Birthplace (State or Foreign Country)<br>Maryland                           |  | 10a. State<br>Maryland                    |  | 10b. County<br>Washington   |  | 10c. City, Town or Location<br>Hagerstown |  |
| Usual Residence of Decedent   |  |  |  |  |   |  |   |  |   |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |   |  |   |  |   |  |
| 10e. Street and Number<br>123 E. Franklin Street  |  |  |  |  |   |  |   |  |   |  |
| 10f. Zip Code<br>21740  |  |  |  |  |   |  |   |  |   |  |
| 10g. Citizen of What Country?<br>U.S.A.   |  |  |  |  |   |  |   |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  |  |   |  |   |  |   |  |
| 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |  |  |  |   |  |   |  |   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  |  |   |  |   |  |   |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |  |  |  |   |  |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br>12 0  |  |  |  |  |   |  |   |  |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  |  |  |  |   |  |   |  |   |  |
| 16b. Kind of Business/Industry<br>Her own home  |  |  |  |  |   |  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Harvey Dowler  |  |  |  |  |   |  |   |  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br>Cora Miller  |  |  |  |  |   |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Molly Stotler /Niece  |  |  |  |  |   |  |   |  |   |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>21912 Martin Circle Hagerstown, Md. 21742  |  |  |  |  |   |  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  |  |   |  |   |  |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Broadfording Cemetery 7/10/96   |  |  |  |  |   |  |   |  |   |  |
| 20c. Location - City or Town, State<br>Hagerstown, Maryland   |  |  |  |  |   |  |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |  |  |  |   |  |   |  |   |  |
| 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 E. Wilson Blvd. Hagerstown, Md. 21740   |  |  |  |  |   |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Myocardial infarction disease</i><br>Due to (or as a consequence of):<br>b. <i>Possible Sepsis</i><br>Due to (or as a consequence of):<br>c. <i>Possible cerebrovascular accident</i><br>Due to (or as a consequence of):<br>d. <i>COPD</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |   |  |   |  |   |  |
| Approximate Interval Between Onset and Death<br>2 week<br>1 week  |  |  |  |  |   |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Thrombocytopenia</i>   |  |  |  |  |   |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |  |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |   |  |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |  |   |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  |  |   |  |   |  |   |  |
| 28a. Date of Injury (Month, Day, Year)  |  |  |  |  |   |  |   |  |   |  |
| 28b. Time of Injury<br>M  |  |  |  |  |   |  |   |  |   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |   |  |   |  |   |  |
| 28d. Describe how injury occurred   |  |  |  |  |   |  |   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |   |  |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  |  |  |   |  |   |  |   |  |
| 29c. License number<br>D4431  |  |  |  |  |   |  |   |  |   |  |
| 29d. Date signed (Month, Day, Year)<br>7/7/96   |  |  |  |  |   |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JERRY L. CORPES, M.D. WASHINGTON COUNTY HOSPITAL<br>HAGERSTOWN, MD 21740  |  |  |  |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 09 1996  |  |  |  |  |   |  |   |  |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21603

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SYLVESTER LAND

2. Date of Death

Month Day Year  
JULY 01, 1996

3. Time of Death

07:48 PM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

BALTIMORE CITY

Funeral  
Director

5. Social Security Number

222-50-9242

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10-12--1959

9. Birthplace (State or Foreign Country)

Wilm., De

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8001 Pulaski Hwy Apt. #3

10f. Zip Code

21241

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Bk Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12thCollege (1-4 or 5+)  
-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Window Cleaner

16b. Kind of Business/Industry

Window Company

17. Father's Name (First, Middle, Last)

Willie C. Land

18. Mother's Name (First, Middle, Maiden Surname)

Loretta Carter

19a. Informant's Name/Relationship (Type, Print)

Anita Jones

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

533 N. Union St. Wilm., De 19805

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Silverbrook Cemetery

Date

7/8/96

20c. Location - City or Town, State

Wilm., De 19805

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

19805  
CONGO FUNERAL HOME P.O. Box 2593 Wilm., De

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Hypoxemia  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Hemoptysis  
Due to (or as a consequence of):

1 DAY

c. Tuberculosis  
Due to (or as a consequence of):

7 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

600 N. WOLFE ST. TOWER 110 BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

JUL 09 1996

32. Registrar's Signature

John Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

5. The fifth part of the report is a summary of the main findings of the study. It includes a brief overview of the research objectives, the methods used, the results obtained, and the conclusions drawn.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21604

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
|---|--|---|---|--|--|---|---|---|---|--|--|--|---|----------------|--|----------------|----------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARY FRANCES LANCASTER</b>  |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>6</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>20:49</b>  |   |   |  |  |  |   |                |  |                |          |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>WASHINGTON COUNTY HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>HAGERSTOWN</b>  |   | 4c. County of Death<br><b>WASHINGTON</b>                                |   |   |  |  |  |   |                |  |                |          |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-18-2651</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                             | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 23, 1915</b>              | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |   |  |  |  |   |                |  |                |          |  |  |
|   | Usual Residence of Decedent  |   |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>WASHINGTON</b>  |  | 10c. City, Town or Location<br><b>HAGERSTOWN</b>   |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |  |   |                |  |                |          |  |  |
|   | 10e. Street and Number<br><b>241 SOUTH PROSPECT STREET</b>   |   |   |  | 10f. Zip Code<br><b>21740</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |   |   |  |  |  |   |                |  |                |          |  |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |   |   |  |  |  |   |                |  |                |          |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALESPERSON</b>                       |  |  | 16b. Kind of Business/Industry<br><b>PHOTOGRAPHY STUDIO</b>   |   |   |   |  |  |  |   |                |  |                |          |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOHN LUTHER LANCASTER</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY JULIA HUMPHREY</b>  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>JULIA L. LANCASTER</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1037 VIEW STREET HAGERSTOWN, MARYLAND 21742</b>  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>REST HAVEN CEMETERY</b>  |  | Date<br><b>07-10-96</b>  |   | 20c. Location - City or Town, State<br><b>HAGERSTOWN, MARYLAND</b>      |   |   |  |  |  |   |                |  |                |          |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>R. Noel Brady</b>  |   |   |  | 22. Name and Address of Facility<br><b>ANDREW K. COFFMAN FUNERAL HOME, INC.<br/>40 E. ANTIETAM ST. HAGERSTOWN, MARYLAND 21740</b>  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
|   | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Sepsis</b><br/>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death<br/><b>4 weeks</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>b. <b>Pneumonia</b><br/>Due to (or as a consequence of):</td> <td><b>4 weeks</b></td> </tr> <tr> <td>c. <b>Aspiration</b><br/>Due to (or as a consequence of):</td> <td><b>Unknown</b></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> <tr> <td colspan="2">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> </tr> </table> |   |   |  |  |   |   |   | Immediate Cause (Final disease or condition resulting in death) | a. <b>Sepsis</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><b>4 weeks</b> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. <b>Pneumonia</b><br>Due to (or as a consequence of): | <b>4 weeks</b> | c. <b>Aspiration</b><br>Due to (or as a consequence of): | <b>Unknown</b> | d. _____ |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Sepsis</b><br>Due to (or as a consequence of):   | Approximate Interval Between Onset and Death<br><b>4 weeks</b>  |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | b. <b>Pneumonia</b><br>Due to (or as a consequence of):  | <b>4 weeks</b>  |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
|   | c. <b>Aspiration</b><br>Due to (or as a consequence of):   | <b>Unknown</b>  |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
|   | d. _____   |   |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |  |  |   |                |  |                |          |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |   | 28d. Describe how injury occurred   |   |  |  |  |   |                |  |                |          |  |  |
| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>S. Iqbal M.D.</b>   |   | 29c. License number<br><b>D 47288</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7-6-96</b>  |   |   |   |  |  |  |   |                |  |                |          |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>S. Iqbal, M.D. 12821 Oak Hill Ave, Hyg. Md.</b>  |  |   |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>   |  | 32. Registrar's Signature<br><b>Johi Hudson-Randall</b>   |   |  |  |   |   |   |   |  |  |  |   |                |  |                |          |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



96 21605

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FELIX LAVAL</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 8 1996</b>  |  |   |  | 3. TIME OF DEATH<br><b>7:00 P M</b>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579 13 2636</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>29</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3/25/67</b>                                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>WASHINGTON, DC</b>  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>WASHINGTON ADVINTIST HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TAKOMA PARK</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>  |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGE'S</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>GAITHERSBURG</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |
| 10e. STREET AND NUMBER<br><b>7900 SPICEBERRY CIRCLE APT. J</b>   |  |  |  | 10f. ZIP CODE   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>STUDENT</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FELIX LAVAL SR.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ADIOLA ADENIJI</b>  |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ADIOLA ADENIJI</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7900 SPICEBERRY CIRCLE #J GAITHERSBURG, MD</b>  |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GLENWOOD CEMETERY 7/17/96</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>WASHINGTON, DC</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Christon Layman</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MORROW &amp; WOODFORD FUNERAL HOME<br/>1622 11th ST NW WASHINGTON, DC 20001</b>  |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AIDS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Seizure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>4 YRS</b><br><b>1 WEEK</b><br><b>2 DAYS</b> |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                    |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Tony P. Kannarakat MD.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-20062</b>   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>JULY 8th 1996</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TONY P. KANNARAKAT, 8201 16th ST, SILVERSPRING, MARYLAND 20910</b>   |  |  |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 22 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Randall</i>   |  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21606

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edwin C. Lawton Sr.

2. Date of Death

Month  
JulyDay  
9Year  
1996

3. Time of Death

11:04 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Charles County Nursing Home

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

178-09-1868

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

October 10, 1913 Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

La Plata

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

205 Morgans Ridge Ct.

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

John Orr Lawton

18. Mother's Name (First, Middle, Maiden Surname)

Lulu Marie Newcomer Lawton

19a. Informant's Name/Relationship (Type, Print)

Edwin C. Lawton, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 Morgans Ridge Ct. La Plata, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bellerive Heritage Garden

Date

7/16

20c. Location - City or Town, State

Crevecoeur, MO

21. Signature of Funeral Service Licensee

M00817

22. Name and Address of Facility

Arehart-Echols Funeral Home, Inc.

P.O. Box 567 La Plata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. sepsis (Urosepsis)

Due to (or as a consequence of):

c. Bladder cancer

Due to (or as a consequence of):

d. Decubitus right foot

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

arteriosclerosis, cerebrovascular

accident, hypertension, Alzheimer

Dementia, Cardiac arrhythmia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D08370

29d. Date signed (Month, Day, Year)

7/19/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul E. Pritchett, Sr., M.D. 118 LaGrange Avenue LaPlata, MD 20646

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 11 1996

32. Registrar's Signature

John Andrew Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



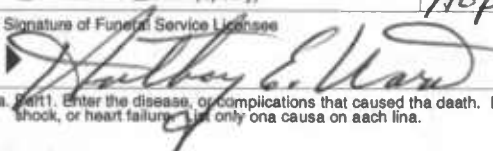


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21607

## Certificate of Death

Reg. No.

|  |   |  |   |                                |  |  |   |  |   |
|--|---|--|---|--------------------------------|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>JANELLE MELODY LEWIS</b>   |  |   |                                | 2. Date of Death<br>Month Day Year<br><b>07-06-96</b>  |  | 3. Time of Death<br><b>2125</b>   |  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |  |   |                                | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |  | 4c. County of Death<br><b>WICOMICO</b>  |  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-08-2149</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>16</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>03-15-80</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>   |   |
|  | Usual Residence of Decedent   |  |   |                                |  |  |   |  |   |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>   | 10b. County<br><b>SOMERSET</b>   | 10c. City, Town or Location<br><b>CRISFIELD</b>   |                                |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |   |
|  | 10e. Street and Number<br><b>27108 CRISFIELD MARION RD.</b>   |  |   |                                | 10f. Zip Code<br><b>21817</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b>  |  |   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>School</b>  |                                | 16b. Kind of Business/Industry<br><b>Student</b>   |  |   |  |   |
| Physician<br>/Medical<br>Examiner                                    | 17. Father's Name (First, Middle, Last)<br><b>JOE T. LEWIS</b>  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sandra Stevenson</b>   |  |   |  |   |
|  | 19a. Informant's Name (Relationship (Type, Print)<br><b>JOE T. LEWIS - Father</b>   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27108 CRISFIELD, MARION RD. 21817</b>  |  |   |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HOPEWELL CEMETERY</b>  |                                | 20c. Location - City or Town, State<br><b>7/13/96 Hopewell MD.</b>   |  |   |  |   |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>314 Cove St. CRISFIELD MD. 21817</b>   |                                |  |  |   |  |   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CLOSED HEAD INJURY</b><br>Due to (or as a consequence of):<br><br><b>b. TRANSPORTATION ACCIDENT</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Due to (or as a consequence of): |  |   |                                |  |  |   | Approximate Interval Between Onset and Death<br><b>3 HRS</b>   |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|  |   |  |   |                                |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|  |   |  |   |                                |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |   |  |   |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>07-06-96</b>   |                                | 28b. Time of Injury<br><b>1817 M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>BICYCLIST STRUCK BY TRUCK</b> |
|  |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET-ROUTE 667-HOPEWELL</b>  |                                |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>CRISFIELD, MD</b>  |  |   |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br> <b>D.M.E.</b>  |                                |  |  |   |  | 29c. License number<br><b>D03599</b>                                  |
| State Registrar  | 29d. Date signed (Month, Day, Year)<br><b>07-07-96</b>  |  |   |                                |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY, MD 21801</b> |  |   |
|  | 31. Date filed (Month, Day, Year)<br><b>JUL 9 1996</b>  |  | 32. Registrar's Signature<br>  |                                |  |  |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



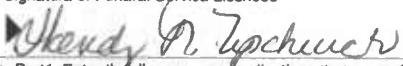
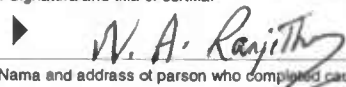
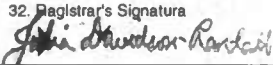
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21608

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |   |  |
|---|--|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARY SUSAN (WIMER) LACY</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>June 22, 1996</b>   |  |  |  | 3. Time of Death<br><b>5:20 PM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |  |  |  | 4c. County of Death<br><b>ALLEGANY</b>                                  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-05-6493</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.  |  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 31, 1910</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>WEST VIRGINIA</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>ALLEGANY</b>   |  | 10c. City, Town or Location<br><b>CUMBERLAND</b>                        |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>135 N. MECHANIC STREET, #801</b>   |  |  |  | 10f. Zip Code<br><b>21502</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b>  |  | Collage (1-4 or 5+) <b></b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PASTRY CHEF</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>A.B.L.</b>                         |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ALBERT WIMER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SUSAN HARPER</b>   |  |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT M. LACY</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12512 GRAMLICH ROAD - LAVALE, MD 21502</b>   |  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>RESTLAWN MEML. GARDENS</b>   |  | Data<br><b>6/25/96</b>   |  | 20c. Location - City or Town, State<br><b>LAVALE, MD</b>                             |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>GEORGE-UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>   |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>METASTATIC CARCINOMA OF CECUM</b><br>Due to (or as a consequence of):<br>b. <b>CARCINOMA OF CECUM</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>2 Months</b><br><b>12 Months</b> |  |   |  |  |  |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS, CORONARY ARTERY DISEASE</b>  |  |   |  |  |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |  |  |   |  |  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                                       |  |
|   | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28t. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |   |  |
|   | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D19318</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>June 27, 1996</b>                          |  |   |  |
| State Registrar   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>N.A. RANJITHAN, M.D.-517 OLDTOWN ROAD, CUMBERLAND, MD 21502</b>   |  |   |  |  |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

500 200 100 0

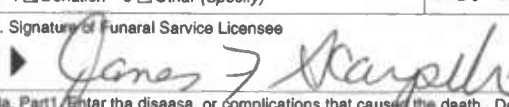
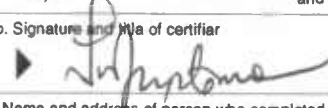
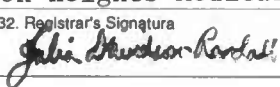
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21609

## Certificate of Death

Reg. No.

|  |   |   |  |   |   |  |  |   |
|--|---|---|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES MILBURN LITTLE</b>                                       |   |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>3</b> Year <b>1996</b> |  | 3. Time of Death<br><b>5:45 A. M.</b>  |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Memorial Hospital &amp; Medical Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>           |  | 4c. County of Death<br><b>Allegany</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-16-4902</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  | If Under 1 Year<br>Months Days                                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec 6, 1924</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |
|  | Usual Residence of Decedent   |   |  |   |   |  |  |   |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Cumberland</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>11904 Little Lane SE</b>  |   |   |  | 10f. Zip Code<br><b>21502</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ret. shipping dept</b>  |   | 16b. Kind of Business/Industry<br><b>tire co.</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Milburn Little</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian J. Green</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Emogene M. Little-wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11904 Little Lane SE; Cumberland, MD 21502</b>  |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Herman Cemetery</b>  |  | Data<br><b>07/05</b>  |   | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Gastrointestinal Bleeding.</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> Due to (or as a consequence of): |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>Two Days</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular Accident.</b>   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|  |   |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and Title of certifier<br>  |  | 29c. License number<br><b>D 33280</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>July 3, 1996</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Sunil Gupta, Johnson Heights Medical Building, Cumberland, MD 21502</b>   |   |   |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 03 1996</b>  |   | 32. Registrar's Signature<br>  |  |   |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Amended #109, 7/5/96,  
NBS, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 21610

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM CHARLES LOLAS

2. Date of Death

Month  
JULY

Day  
4

Year  
1996

3. Time of Death

11:55 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

029-01-2534

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

8. Under 1 Year

Months Days

9. Under 24 Hrs.

Hours Min.

6. Date of Birth

Month, Day, Year  
May 2, 1915

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Allegany

10c. City, Town, or Location

Cumberland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

701 Furnace Street

10f. Zip Code

21539

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

William Lolos

18. Mother's Name (First, Middle, Maiden Surname)

Angeline Cotelu

19a. Informant's Name/Relationship (Type, Print)

Janette Lolos-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

701 Furnace St., Cumberland, Md. 21502

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory July 5, 1996 Cumberland, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jane E. McKenzie

22. Name and Address of Facility

Eichhorn-McKenzie Funeral Home  
Lonaconing, Md. 21539

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma of colon, metastatic to lungs and liver

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive pulmonary disease

Transitional cell carcinoma of urinary bladder

Atherosclerotic coronary artery disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas J. Devlin MD

29c. License number

D21488

29d. Date signed (Month, Day, Year)

JULY 4, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas J. Devlin MD, 20 Douglas Ave., Lonaconing, Md 21539

31. Date filed (Month, Day, Year)

JUL 05 1996

32. Registrar's Signature

Jane E. McKenzie

State  
Registrar

Baltimore, Maryland 21215-0020

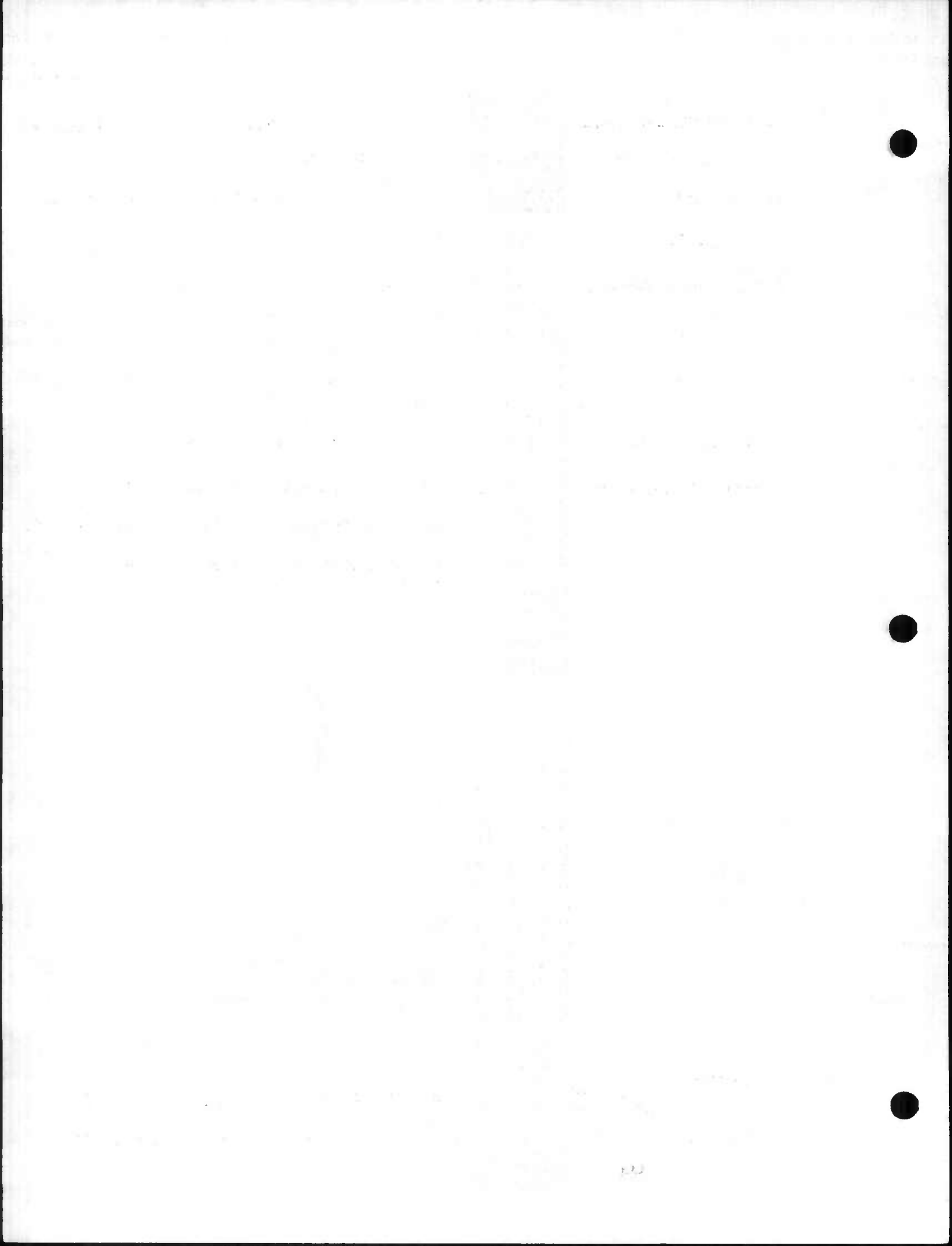
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



96 2161

Reg. No.

DHMH 16 Rev 6/95



96 21612

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert Norton Leverage</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 2, 1996</b>  |  | 3. TIME OF DEATH<br>P M<br><b>6:35 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>221-09-5566</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 2, 1915</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Kansas</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Wesleyan Health Care Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Denton</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Caroline</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Caroline</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Denton</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. ZIP CODE<br><b>21629</b>  |  |
| 10f. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br><b>WW II</b> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Caucasian</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>         |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Salesman</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Automobile</b>  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>John R. Leverage</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Viola Elizabeth Norton</b>  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>William N. Leverage Son</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9409 Shouse Drive, Vienna, Virginia 22182</b>      |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cemetery Slaughter Neck Methodist 7/5</b>  |  | 20c. LOCATION — City or Town, State<br><b>Argo Corners, Delaware</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Handwritten Signature</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MOORE FUNERAL HOME, P.A.<br/>12 SOUTH SECOND ST. Denton, Md 21629</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COPD</b>   |  |  |  |  |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <b>1</b> YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Handwritten Signature</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D32136</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/5/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Form 22, three Print)<br><b>Gary J. Sprouse, M.D. 2108 Diconato Drive, Chester, Maryland 21619</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL - 5 '96</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Handwritten Signature</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



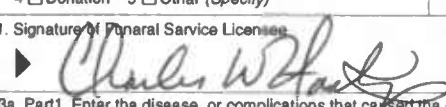
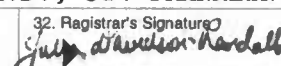
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21613

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>HAZEL MARIE MUMFORD  |  |   | 2. Date of Death<br>Month Day Year<br>JUNE 29 1996   |  | 3. Time of Death<br>3:50 AM  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>ATLANTIC GENERAL HOSPITAL  |  |   | 4b. City, Town, or Location of Death<br>BERLIN   |  | 4c. County of Death<br>WORCESTER   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-12-3715   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>75 Yrs.  | 8. Date of Birth (Month, Day, Year)<br>MAR. 8, 1921  | 9. Birthplace (State or Foreign Country)<br>MARYLAND                                 |   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND   |  | 10b. County<br>WORCESTER  |  | 10c. City, Town or Location<br>BISHOPVILLE   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  | 10e. Street and Number<br>9162 PEERLESS ROAD   |  |   | 10f. Zip Code<br>21813   |  | 10g. Citizen of What Country?<br>USA   |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7<br>Collage (1-4or 5+) 7   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER                                |  | 16b. Kind of Business/Industry<br>OWN HOME   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>WILLIAM R. JONES  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>RITA ANN SMITH  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>GRACIE D. DREW / NIECE   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9202 PEERLESS ROAD, BISHOPVILLE, MARYLAND 21813 |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>CURTIS CEMETERY   |  | Data<br>7/3/96   |  | 20c. Location - City or Town, State<br>BISHOPVILLE, MARYLAND  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br>HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. MYOCARDIAL INFARCTION<br>Due to (or as a consequence of):<br>b. UPPER GASTROINTESTINAL BLEED<br>Due to (or as a consequence of):<br>c. CEREBROVASCULAR DISEASE<br>Due to (or as a consequence of):<br>d. DIABETES<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |   | Approximate Interval Between Onset and Death<br>6 days   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |   |  |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br>046257  |   | 29d. Date signed (Month, Day, Year)<br>6/29/96   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>EDWIN CASTANEDA, M.D., 314 FRANKLIN AVENUE, SUITE 103, BERLIN, MD. 21811   |  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 02 1996   |  | 32. Registrar's Signature<br>   |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21614

|   |   |  |   |  |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LEON MEINSTER</b>                            |  |   |  | 2. Date of Death<br>Month Day Year<br><b>June 29, 1996</b> |  | 3. Time of Death<br><b>7:32 P.M.</b>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1706 Carver Square</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>Salisbury</b>   |  | 4c. County of Death<br><b>Wicomico</b>   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-01-5959</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>April 23, 1916</b>   |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                 |  |   |  |  |  |  |  |  |
| Usual Residence of Decedent   |   |  |   |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Wicomico</b>   |   | 10c. City, Town or Location<br><b>Salisbury</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>1706 Carver Square</b>   |   |  |   | 10f. Zip Code<br><b>21801</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                                  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5</b>   |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dentist</b>  |  |  | 16b. Kind of Business/Industry<br><b>Dentistry</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Louis Meinster</b>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie Stubnitz</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gwendolyn M. Meinster</b>  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1706 Carver Square, Salisbury, MD 21801</b>  |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory</b>  |  | Data<br><b>7/1/96</b>                                      |  | 20c. Location - City or Town, State<br><b>Salisbury, MD</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |   | 22. Name and Address of Facility<br><b>Holloway Funeral Home<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Metastatic Carcinoma</b><br>Due to (or as a consequence of):<br>b. <b>Large Cell Undifferentiated Carcinoma of the Lung</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |  |   |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>6/93</b>   |   |  |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                            |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
|   |   |  | 28d. Describe how Injury occurred   |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  | 29b. Signature and title of certifier<br>  |  |  | 29c. License number<br><b>201969</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/1/96</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JAMES L. CLIFFORD MD 106 PINE BLUFF RD Suite 12 SALISBURY, MD 21801</b>  |   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 02 1996</b>   |   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21615

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Beauford Garnett Mutter</i>   |  |   |  | 2. Date of Death<br>Month <i>July</i> Day <i>2</i> Year <i>1996</i>  |  | 3. Time of Death<br><i>1400</i>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>PENINSULA REGIONAL MEDICAL CENTER</i>   |  |   |  | 4b. City, Town, or Location of Death<br><i>SALISBURY</i>   |  | 4c. County of Death<br><i>WICOMICO</i>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>233-14-1428</i>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>76</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>Nov 5 1919</i>                         |  |
|   | 9. Birthplace (State or Foreign Country)<br><i>Virginia</i>  |  | 10a. State<br><i>Va.</i>  |  | 10b. County<br><i>Accomack</i>   |  | 10c. City, Town or Location<br><i>Chincoteague</i>                               |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><i>8275 Seaweed Dr</i>  |  | 10f. Zip Code<br><i>23336</i>  |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>                                   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>WWII</i> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>          |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>2</i>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Meatcutter</i>                                |  | 16b. Kind of Business/Industry<br><i>Meatland Pocomoke</i>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>Garnett R. Mutter</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Maude Mae Messer Mutter</i>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Kathy Mutter Daughter</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>Virginia Beach Va</i>  |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Salisbury Crematory</i>  |  | Date<br><i>7-3-96</i>  |  | 20c. Location - City or Town, State<br><i>Salisbury Md.</i>                      |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Constance Lyle Baker Bailey</i>  |  |   |  | 22. Name and Address of Facility<br><i>6327 Church St, Chincoteague Va 23336</i>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Cardiac arrest</i><br>Due to (or as a consequence of):<br>b. <i>Massive Myocardial Infarction</i><br>Due to (or as a consequence of):<br>c. <i>Atherosclerotic heart disease</i><br>Due to (or as a consequence of):<br>d. |  |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| State Registrar   | 29b. Signature and title of certifier<br><i>Charles L. Baker</i>   |  |   |  | 29c. License number<br><i>019289</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>7/2/96</i>                             |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Charles L. Baker MD PO Box 2636 Salisbury MD 21801</i>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 03 1996</i>   |  |  |   |  |  |  |  |  |
| 32. Registrar's Signature<br><i>Julia Wheeler-Randall</i>   |  |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21616

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
|---|--|---|---|--|--|--|--|-----------------------------------|---|------------------------------|---|-------------------------|-------|---------------------------------|-------|----------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Richard Eugene McDonald  |   |   |  | 2. Date of Death<br>Month Day Year<br>July 5, 1996   |  | 3. Time of Death<br>7:52 P.M.                                    |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital  |   |   |  | 4b. City, Town, or Location of Death<br>Frederick  |  | 4c. County of Death<br>Frederick                                 |                                   |   |                              |   |                         |       |                                 |       |                      |
| Funeral<br>Director   | 5. Social Security Number<br>215-86-3897   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>33 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>June 15, 1963   | 9. Birthplace (State or Foreign Country)<br>Md.                  |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | Usual Residence of Decedent  |   |   |  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
| To Be Completed by Funeral Director   | 10a. State<br>Md.  | 10b. County<br>Frederick  | 10c. City, Town or Location<br>Middletown   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | 10e. Street and Number<br>6624 Old Middletown Rd.  |   |   | 10f. Zip Code<br>21769   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>laborer                                  |  | 16b. Kind of Business/Industry<br>construction   |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | 17. Father's Name (First, Middle, Last)<br>Richard D. McDonald   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nancy Butts   |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Kimberly D. McDonald (Wife)  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6624 Old Middletown Rd., Middletown, Md. 21769  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Locust Valley Cemetery  |  | Date<br>7/9  |  | 20c. Location - City or Town, State<br>Middletown, Md.           |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br>Donald B. Thompson Funeral Home<br>31 E. Main St., Middletown, Md. 21769   |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>metabolic acidosis</u></td> <td>Approximate Interval Between Onset and Death<br/>36 hr</td> </tr> <tr> <td>b. <u>renal failure</u></td> <td>36 hr</td> </tr> <tr> <td>c. <u>Groom Negative Sepsis</u></td> <td>40 hr</td> </tr> <tr> <td>d. <u>leukopenia</u></td> <td>6 mo</td> </tr> </table> |   |   |  |  |  |  |                                   | Immediate Cause (Final disease or condition resulting in death) | a. <u>metabolic acidosis</u> | Approximate Interval Between Onset and Death<br>36 hr | b. <u>renal failure</u> | 36 hr | c. <u>Groom Negative Sepsis</u> | 40 hr | d. <u>leukopenia</u> |
| Immediate Cause (Final disease or condition resulting in death)   | a. <u>metabolic acidosis</u>   | Approximate Interval Between Onset and Death<br>36 hr   |   |  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | b. <u>renal failure</u>  | 36 hr   |   |  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | c. <u>Groom Negative Sepsis</u>  | 40 hr   |   |  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
|   | d. <u>leukopenia</u>   | 6 mo  |   |  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>AIDS</u>   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                   |   |                              |   |                         |       |                                 |       |                      |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred |   |                              |   |                         |       |                                 |       |                      |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
| 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br>D 14620   |  | 29d. Date signed (Month, Day, Year)<br>July 6, 1996  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. P. Gregory Rausch 501 W. Seventh St., Frederick, Md. 21701  |  |   |   |  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |
| 31. Date filed (Month, Day, Year)<br>JUL 08 1996  |  |   |   | 32. Registrar's Signature<br>  |  |  |  |                                   |   |                              |   |                         |       |                                 |       |                      |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text covering the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21617

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |  |  |
|---|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Calvin L Montague</b>                            |   |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>1</b> Year <b>1996</b> |  | 3. Time of Death<br><b>6:42pm</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>          |  | 4c. County of Death<br><b>Anne Arundel</b>                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>226-15-3130</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.   | If Under 1 Year<br>Months Days                                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 15 1941</b> | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |  |
| 10a. State<br><b>MAARYLAND</b>  |   | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>SEVERNA PARK</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>108 EARLEIGH HEIGHTS ROAD</b>  |   |   |  | 10f. Zip Code<br><b>21146</b>  |   | 10g. Citizen of What Country?<br><b>US</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1962-64</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>3yrs.</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SUPERVISOR</b>   |   | 16b. Kind of Business/Industry<br><b>ANNE ARUNDEL CO. PUBLIC UTILITIES</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>MONROE MONTAGUE</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CLARA THORNTON</b>   |   |  |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>JENNIE B. MONTAGUE (WIFE)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>108 EARLEIGH HEIGHTS RD. SEVERNA PARK, MD. 21146</b>                                     |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>  |  | Date<br><b>7/9/96</b>  |   | 20c. Location - City or Town, State<br><b>BALTIMORE, MD.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Harry D. Reese</b>  |   |   |  | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. END STAGE RENAL DISEASE</b><br>Due to (or as a consequence of):<br><b>b. INSULIN DEPENDENT DIABETES</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Due to (or as a consequence of): |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>- chronic long term illness</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Peripheral vascular disease</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br><b>Geoffrey Sanders M.D.</b>   |  |  |   |  |  |  |
|   |   | 29c. License number<br><b>D40403</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/2/96</b>   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Geoffrey Sanders, M.D., Suite 406, 1600 Crum Hwy., S.W., Glen Burnie, Md</b>   |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>   |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21618

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |  |   |
|--|---|---|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS JOSEPH MARLOWE</b>  |   |  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>6</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>1400</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5 ST. LOUIS AVENUE</b>   |   |  |   | 4b. City, Town, or Location of Death<br><b>OCEAN CITY</b>  |  | 4c. County of Death<br><b>WORCESTER</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>069 12 4193</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>72</b> (73) Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>8-6-22</b>  | 9. Birthplace (State or Foreign Country)<br><b>NY</b>   |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD.</b>  |   | 10b. County<br><b>WORCESTER</b>  |   | 10c. City, Town or Location<br><b>OCEAN CITY</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>5 ST. LOUIS AVE.</b>   |   |  |   | 10f. Zip Code<br><b>21842</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MENS CLOTHING</b>  |  | 16b. Kind of Business/Industry<br><b>RETAIL</b>  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>James Minissale</b>   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Josephine Caputo</b>   |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>GREG MARLOWE</b>   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5 ST. LOUIS AVE., OCEAN CITY, MD.</b>  |  |  |   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SALISBURY CREMATORY</b>   |   | Data<br><b>7-8</b>   |  | 20c. Location - City or Town, State<br><b>SALISBURY, MD.</b>                                   |   |
|  | 21. Signature of Funeral Service Licensee<br>   |   |  |   | 22. Name and Address of Facility<br><b>ULLRICH FUNERAL HOME BERLIN, MD., 2181</b>  |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Carcinoma of Lung</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |  |   |  |  |  |   |
|  | Approximate Interval Between Onset and Death<br><b>5 years</b>  |   |  |   |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|  |   |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  | 29b. Signature and title of certifier<br>             |  | 29c. License number<br><b>030690</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 8, 1996</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James E. Martin M.D., 145 E. Carroll St., Salisbury, MD.</b>  |   |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>  |   | 32. Registrar's Signature<br>   |  |   |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 21619

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |                                |   |  |
|--|--|--|---|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARY KATHERINE ELISE MARVEL  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>07 10 1996  |                                | 3. TIME OF DEATH<br>2:25 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-28-8721   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (in yrs. last birthday)<br>92 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br>AUG 27, 1903   |  |
| 8. FACILITY NAME (If not institution, give street and number)<br>FAHRNEY-KEEDY MEMORIAL HOME   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BOONSBORO  |                                | 9c. COUNTY OF DEATH<br>WASHINGTON   |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |                                |   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>WASHINGTON  |   | 10c. CITY, TOWN OR LOCATION<br>BOONSBORO  |                                | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>8507 MAPLEVILLE ROAD   |  |  |   | 10f. ZIP CODE<br>21713  |                                | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11<br>College (1-4 or 5+) 11   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>SUPERINTENDENT  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>RETIREMENT HOME   |                                |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>GRAHAM PORTER   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>SALLY MURPHY   |                                |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>CARLTON A. MARVEL JR.  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>37 LINDER DR, SUGAR MILL WOODS, HOMOSASSA, FL 34446  |                                |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>SMITHSBURG CREMATORY 7/11/96  |   | 20c. LOCATION — City or Town, State<br>SMITHSBURG, MARYLAND   |                                |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Paul M. Dean  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>BAST FUNERAL HOME 7606 Old National Pike Boonsboro, MD 21713  |                                |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |   |                                |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |   |   |                                |   |  |
| a. <i>Cardiovascular Accident</i>  |  |  |   |   |                                |   |  |
| b. <i>Anterior wall Myocardial Infarction</i>  |  |  |   |   |                                |   |  |
| c. <i>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</i>  |  |  |   |   |                                |   |  |
| d. <i>None</i>   |  |  |   |   |                                |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Anemia</i>  |  |  |   |   |                                |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   |   |                                |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |   |   |                                |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |   |   |                                |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |                                |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |                                |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |                                |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |                                |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Vasant Datta</i>   |  |  |   | 29c. LICENSE NUMBER<br>D18019   |                                | 29d. DATE SIGNED (Month, Day, Year)<br>July 11, 1996  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Vasant Datta 334 Mill Street, Hagerstown, MD 21740  |  |  |   |   |                                |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 11 1996   |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Harker</i>   |   |   |                                |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21620

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Albert Chester Mathes</b>  |  |  |  | 2. Date of Death<br>Month: <b>July</b> Day: <b>08</b> Year: <b>1996</b>  |  | 3. Time of Death<br><b>0125</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Medpointe one Price Drive</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>  |  | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>050 03 5330</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 28 1901</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Manhattan, NY</b>  |  | 10a. State<br><b>Md</b>  |  | 10b. County<br><b>Cecil</b>  |  | 10c. City, Town or Location<br><b>Elkton, Md</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>one Price Drive</b>   |  | 10f. Zip Code<br><b>21921</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b></b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>owner/operator</b>                 |  | 16b. Kind of Business/Industry<br><b>Amusement</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Albert Mathes</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Genevieve Dowling</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eleanor Reilly/Niece</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>115 Eleanor Street, Elkton, Maryland 21921</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |
| Physician<br>/Medical<br>Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Immaculate Conception Cem.</b>   |  | 20c. Location - City or Town, State<br><b>Cherry Hill, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Donald S. Hicks</b>  |  | 22. Name and Address of Facility<br><b>Hicks Home for Funerals, P.A.<br/>103 W. Stockton St., Elkton, Maryland 21921</b>   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Chronic renal failure</b><br>Due to (or as a consequence of):<br><b>c. Chronic congestive heart failure</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>3 yrs</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020  | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>Cancer of Prostate</b><br><b>Chronic renal failure</b><br><b>Chronic congestive heart failure</b>  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
|   | 29b. Signature and title of certifier<br><b>Wallace Obenshain, MD</b>   |  | 29c. License number<br><b>007129</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 08 1996</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>WALLACE OBENSHAIN, MD Cecilton, Md 21913</b>  |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |  | 33. Date of Death (Month, Day, Year)<br><b>July 08 1996</b>  |  | 34. Time of Death<br><b>0125</b>   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21621

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Henry McGlothlin

2. Date of Death

Month  
JulyDay  
1Year  
1996

3. Time of Death

9:50 AM

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

219-05-9476

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
April 20, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Port Deposit

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8 Stayman Drive

10f. Zip Code

21904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: WW II Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
Twelve YearsCollege (1-4 or 5+)  
-----

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Quarter Master Advisor

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Thomas H. McGlothlin

18. Mother's Name (First, Middle, Maiden Surname)

Laura Belle VanDyke

19a. Informant's Name/Relationship (Type, Print)

Candace L. Artim

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

418 Sapphire Drive, Sarasota, Florida 34234

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

West Nottingham Cemetery

Date

7/5/96

20c. Location - City or Town, State

Colora, Maryland

21. Signature of Funeral Service Licensee

Thomas M. Patterson, Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home  
Perryville, Maryland 21903

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LEFT PNEUMOTHORAX, ACUTE  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. PNEUMONIA, RIGHT LUNG, SEVERE  
Due to (or as a consequence of):

4 DAYS

c. ISCHEMIC HEART DISEASE  
Due to (or as a consequence of):

15 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Andrew Nowakowski MD

29c. License number

D08096

29d. Date signed (Month, Day, Year)

JULY 2, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW NOWAKOWSKI, MD

135 N. MAIN ST, BELAIR, MD 21014

31. Date filed (Month, Day, Year)

JUL 05 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitTo Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 21622

Reg. No.

|   |   |   |   |   |   |  |   |  |  |  |
|---|---|---|---|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>JAMES PATRICK MOORE 3RD                         |   |   |   | 2. Date of Death<br>Month JULY Day 5th Year 1996  |  | 3. Time of Death<br>6:50 p.m.   |  |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>HOMWOOD RETIREMENT CENTER |   |   |   | 4b. City, Town, or Location of Death<br>WILLIAMSPORT, MD  |  | 4c. County of Death<br>WASHINGTON                                     |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>143-30-3767  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                    |   | 7. Age (In yrs. last birthday)<br>57 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>April 17, 1939                 |  | 9. Birthplace (State or Foreign Country)<br>New Jersey |  |
|   | Usual Residence of Decedent   |   |   |   |   |  |   |  |  |  |
| 10a. State<br>Maryland  |   | 10b. County<br>Washington   |   | 10c. City, Town or Location<br>Hagerstown   |   |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>1815 Brightwood Drive   |   |   |   | 10f. Zip Code<br>21740  |   | 10g. Citizen of What Country?<br>U.S.A.  |   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white      |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0-12 College (1-4 or 5+) 4   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>industrial engineer  |   |  | 16b. Kind of Business/Industry<br>AUTO PARTS DISTRIBUTOR<br>truck Co. |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>James Patrick Moore, Jr.   |   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Round   |  |   |  |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br>Mrs. Carole A. Moore / Wife   |   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1660 Langley Drive, Hagerstown, Maryland 21740 |  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery |   |   | Date<br>7/9/96   |   | 20c. Location - City or Town, State<br>East Hanover, NJ  |  |  |
| 21. Signature of Funeral Service Licensee<br>James L. Spicer  |   |   |   |   | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 East Wilson Blvd., Hagerstown, Maryland 21740                                   |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. ACUTE RENAL FAILURE<br>Due to (or as a consequence of):<br>b. DEHYDRATION<br>Due to (or as a consequence of):<br>c. INABILITY TO SWALLOW<br>Due to (or as a consequence of):<br>d. MULTIPLE STROKES<br>Approximate Interval Between Onset and Death<br>DAYS<br>1-2 WKS<br>3 WKS<br>YEARS |   |   |   |   |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ACUTE URINARY ENCEPHALITIS  |   |   |   |   |   |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |   |   |   |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |   |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |   |   |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |   |   |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |   |   |   |   |   |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>M. E. Metzner, MD  |   | 29c. License number<br>D17067   |   | 29d. Date signed (Month, Day, Year)<br>7/6/96  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>STEPHEN E. METZNER, MD 747 Northman Ave. Hagerstown, MD   |   |   |   |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 08 1996  |   | 32. Registrar's Signature<br>John Anderson-Randall  |   |   |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Amended #5 17, 196, 7/8/96, N&amp;S, Allegany County

96 21623

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |                                 |   |  |   |  |
|--|--|--|--|---|--|--|---------------------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Kenneth William Messmer  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 6, 1996  |  | 3. TIME OF DEATH<br>5:29 a m   |                                 |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-24-0282   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 13, 1928                               |                                 | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>11814 Crocus Avenue SW   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cumberland   |  |  | 9c. COUNTY OF DEATH<br>Allegany |   |  |   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Allegany   |  | 10c. CITY, TOWN OR LOCATION<br>Cumberland  |                                 | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>11814 Crocus Avenue SW   |  |  |  | 10f. ZIP CODE<br>21502  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |                                 |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Korean War |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |                                 |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Administrator                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br>State Institution   |  |  |                                 |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Raymond G. Messmer  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ellen M. (Mofatt)  |  |  |                                 |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Linda L. Messmer   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11814 Crocus Ave SW, Cumberland, Maryland 21502  |  |  |                                 |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rocky Gap Veterans Cemetery 7/9   |  | DATE<br>7/9   |  | 20c. LOCATION — City or Town, State<br>Flinstone, Maryland                           |                                 |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Kight Funeral Home<br>309-311 Decatur St., Cumberland, MD. 21502  |  |  |                                 |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Arteriosclerotic heart disease<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>Diabetes<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |                                 | Approximate interval Between Onset and Death<br>5 days<br>uk days<br>10 yrs                               |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>obesity  |  |  |  |   |  |  |                                 | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |  |                                 |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                                      |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                 |  |  |                                 |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 26a. DATE OF INJURY<br>(Month, Day, Year)  |  | 26b. TIME OF INJURY<br>M  |  | 26c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                 | 26d. DESCRIBE NOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  | 29c. LICENSE NUMBER<br>D 09157  |  | 29d. DATE SIGNED (Month, Day, Year)<br>July 8, 1996                                  |                                 |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Paul Snow, M.D. 124 W #rd St Cumberland, Maryland 21502   |  |  |  |   |  |  |                                 |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 08 1996   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |                                 |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21624

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN J. MACKEY

2. Date of Death

Month Day Year  
JULY 6, 1996

3. Time of Death

3:50 PM

4a. Facility Name (If not institution, give street and number)

ST. JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

218-14-4980

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 18, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

201 N. Centre Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

Pastor

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Catholic Church

17. Father's Name (First, Middle, Last)

Maurice F. Mackey, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Katherine A. (Murnane)

19a. Informant's Name/Relationship (Type, Print)

Maurice Mackey—brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Baldwin, MD

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Patrick's Cemetery

Date

07/11

20c. Location - City or Town, State

Mt. Savage, MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home

Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 25686

29d. Date signed (Month, Day, Year)

July 7, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EBRAHIM IPAKCHI, M.D., 7600 OSLER DR., TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

JUL 9 1996

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96 21625

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert LeRoy Matthews</b>   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>July</b> DAY <b>8</b> YEAR <b>1996</b>   |  | 3. TIME OF OATH<br><b>6:15 A. M.</b>                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-20-6927</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 12, 1927</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>18007 L. Georges Creek Rd. S.W.</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF OATH<br><b>Barton</b>   |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>                      |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Allegany</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Barton</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 10e. STREET AND NUMBER<br><b>18007 Lower Georges Cr. Rd. S.W.</b>  |  | 10f. ZIP CODE<br><b>21521</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b><br>College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Saw mill operator</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Lumber</b>   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward Matthews</b>  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hazel Smith</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Emma Jean Matthews</b>  |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21521<br/>18007 Lower Georges Cr. Rd. Barton, Md.</b> |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cumberland crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>2996 Cumberland, Md.</b>  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James McKnight</b>   |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fiechhorn-McKenzie Funeral Home 8<br/>East Main St. Lovanokup, Md. 21539</b>                                       |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |   | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Dysrhythmia</b>   |  |  |  |   |  |   |  |   | 2 hours                                      |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |   | 2 hours                                      |
| b. <b>Acute Myocardial Infarction</b>  |  |  |  |   |  |   |  |   |  |
| c. <b></b>   |  |  |  |   |  |   |  |   |  |
| d. <b></b>   |  |  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |  |  |   |  |   |  |   | July 10 1996                                 |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James McKnight</b>   |  | 29c. LICENSE NUMBER<br><b>D 21244</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/8/96</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jesus tan, M.D. Frostburg Plaza, Frostburg, Md. 21532</b>  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 10 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Anderson-Randall</b>   |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21626

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |  |  |   |  |
|---|---|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Flora M. Nye  |   |   |   | 2. Date of Death<br>Month Day Year<br>July 4 1996  |  | 3. Time of Death<br>4:30PM                                       |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>4427 Windsor Farm Road  |   |   |   | 4b. City, Town, or Location of Death<br>Harwood  |  | 4c. County of Death<br>Anne Arundel                              |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>205-05-9868  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>80 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>April 6 1916              |   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |   | Usual Residence of Decedent   |   |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>PA  | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Pottstown  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   | 10e. Street and Number<br>1102 Bellevue Avenue  |   |   | 10f. Zip Code<br>19464                    |  | 10g. Citizen of What Country?<br>United States                                       |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>3   |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife                                |   | 16b. Kind of Business/Industry<br>Home   |  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Frank F. Zissa   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Flora May Huetter   |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Jan A. Nye-Son  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1715 St. Peters Rd. Pottstown, Pennsylvania 19465   |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Highland Memorial Park  |   | Date<br>7/8/96   |  | 20c. Location - City or Town, State<br>Pottstown, Pennsylvania   |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc.<br>147 Duke Of Gloucester St. Annapolis, MD 21401  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Mitral Stenosis LVNL CA</u><br>Due to (or as a consequence of):<br>b. <u>Brain Metastasis</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |  |   | Approximate Interval Between Onset and Death<br>6 mo<br>6 mo   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner   |   | 29b. Signature and title of certifier<br>   |   |   |  |  |  |   |  |
| 29c. License number<br>D31188   |   | 29d. Date signed (Month, Day, Year)<br>July 5, 1996   |   |   |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Richard Colgan, M.D. 600 Ridgley Avenue Annapolis, MD 21401 (410-224-0070)  |   |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 09 1996  |   | 32. Registrar's Signature<br>   |   |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

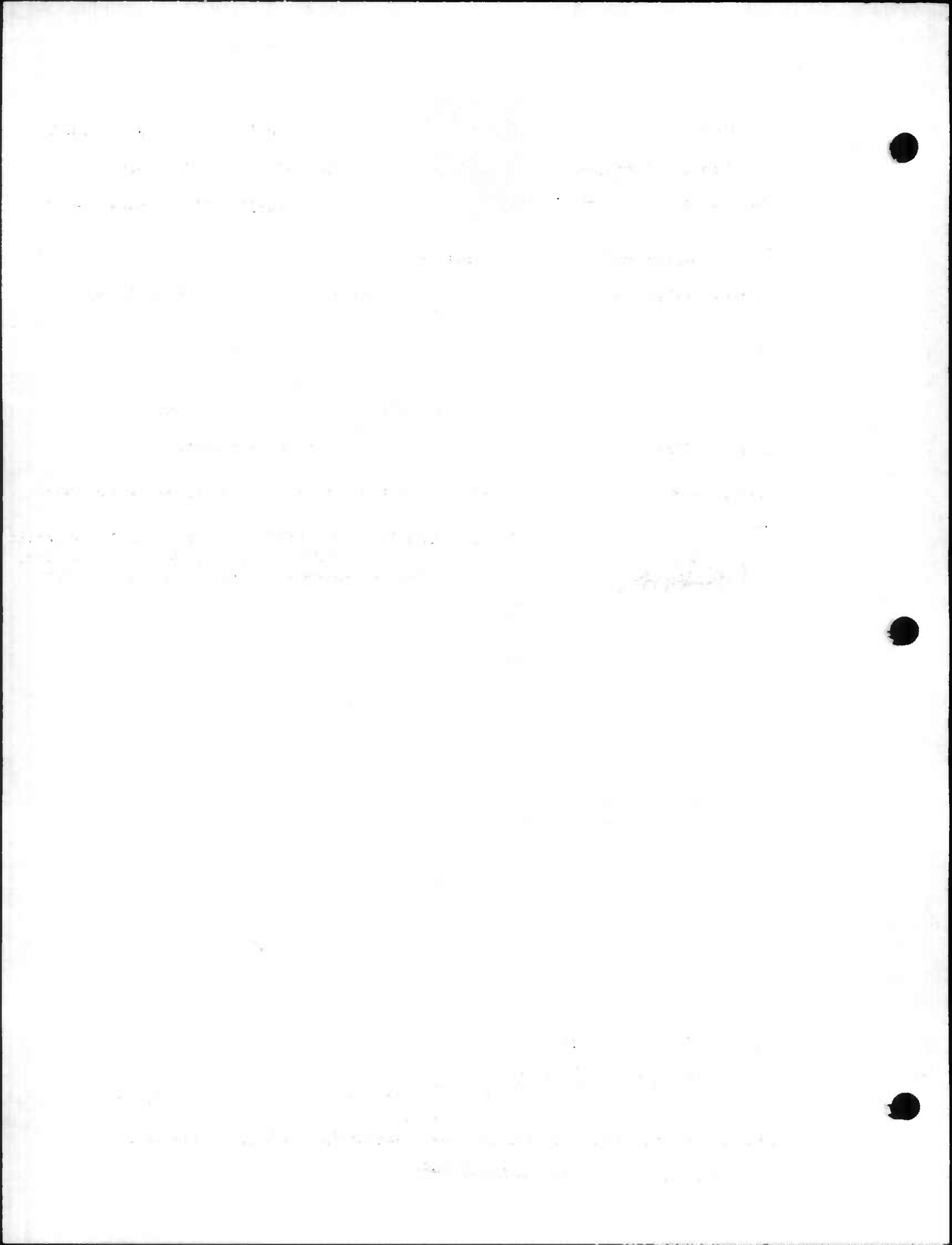
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21627

Reg. No.

|   |   |  |   |   |  |                                |  |  |
|---|---|--|---|---|--|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Russell HILL Nickell  |  |   | 2. Date of Death<br>July 6 1996 Year            |  | 3. Time of Death<br>2:20 AM    |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Physicians Memorial Hospital  |  |   | 4b. City, Town, or Location of Death<br>LaPlata |  | 4c. County of Death<br>Charles |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>235-26-2845  |  | 6. Sex<br>XXM 2□F   |   | 7. Age (In yrs. last birthday)<br>83 Yrs.  |                                | 8. Date of Birth (Month, Day, Year)<br>OCT. 22, 1912   |  |
|   | 9. Birthplace (State or Foreign Country)<br>VIRGINIA  |  | 10a. State<br>MARYLAND  |   | 10b. County<br>CHARLES   |                                | 10c. City, Town or Location<br>BRYANTOWN   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1□Yes 2□No   |  | 10e. Street and Number<br>5679 HUCKLEBERRY DRIVE  |   | 10f. Zip Code<br>20617   |                                | 10g. Citizen of What Country?<br>UNITED STATES   |  |
|   | 11. Marital Status<br>1□Never Married 2XMarried<br>3□Widowed 4□Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1□Yes 2XNo<br>If Yes, Give Year or Dates:                              |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1□Yes 2XNo Specify:                  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+) 0   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>MECHANIC |   | 16b. Kind of Business/Industry<br>AUTOMOBILE   |                                | 17. Father's Name (First, Middle, Last)<br>TEMPEST HILL NICKELL  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>GEORGIA LEMONS   |  | 19a. Informant's Name/Relationship (Type, Print)<br>BETTY L. REED - DAUGHTER  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>27165 MORGANZA TURNER RD., MECHANICSVILLE, MD 20659 |                                | 20a. Method of Disposition<br>1XBurial 2□Cremation 3□Removal from State<br>4□Donation 5□Other (Specify)            |  |
| Physician<br>/Medical<br>Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>TRINITY MEM. GARDENS, JULY 9, 1996  |  | 20c. Location - City or Town, State<br>WALDORF, MARYLAND  |   | 21. Signature of Funeral Service licensee<br>MARK G. BROHAWN M00053  |                                | 22. Name and Address of Facility<br>THE HUNTI FUNERAL HOME, INC.<br>P.O. BOX 156, WALDORF, MARYLAND 20604          |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. SEPTICEMIA<br>Due to (or as a consequence of):<br>b. MULTI-ORGAN FAILURE<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death<br>2 WEEKS<br>2-3 WEEKS  |   | 23b. Did tobacco use contribute to the cause of death?<br>1□Yes 2□No 3□Probably 4□Unknown  |                                | 24a. Was an autopsy performed?<br>1□Yes 2XNo   |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1□Yes 2□No   |  | 25. Was case referred to medical examiner?<br>1□Yes 2XNo  |   | 26. Place of Death (Check only one)<br>Hospital: 1XInpatient 2□ER/Outpatient 3□DOA Other: 4□Nursing Home 5□Residence 6□Other (Specify)               |                                | 27. Manner of Death<br>1XNatural 2□Accident 3□Suicide 4□Homicide 5□Pending investigation 6□Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1□Yes 2□No   |                                | 28d. Describe how injury occurred  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 29a. Certifier (Check only one)<br>1XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2□Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>Attending  |   | 29c. License number<br>D44436  |                                | 29d. Date signed (Month, Day, Year)<br>July 6 1996   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Ashvinkumar Patel, MD 603 Post Office Road Suite 207 Waldorf MD 20602   |  | 31. Date filed (Month, Day, Year)<br>JUL 10 1996  |   | 32. Registrar's Signature<br>John Anderson Randall   |                                |  |  |




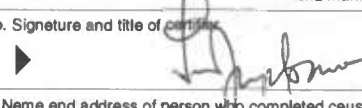
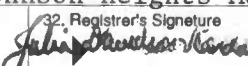
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21628

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |  |   |
|---|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARY MARGARET NOLAN</b>  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>July 2, 1996</b> |  | 3. Time of Death<br><b>1:15 A.M.</b>   |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Memorial Hospital &amp; Medical Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b> |  | 4c. County of Death<br><b>Allegany</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-26-9482</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Mar 1, 1931</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Cumberland</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>567 Cromwell Terrace</b>   |   |   |  | 10f. Zip Code<br><b>21502</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b>homemaker</b>   |   |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>homemaker</b>   |   | 16b. Kind of Business/Industry<br><b>own home</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Arthur Fazenbaker</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie C. Enfield</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Daniel F. Nolan-husband</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>567 Cromwell Terrace; Cumberland, MD 21502</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cumberland Crematory</b>   |  | Date<br><b>07-05</b>   |   | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Carcinoma of lung</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>6 months</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive pulmonary disease</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>  |  |  |   |  |  |   |
|   |   | 29c. License number<br><b>D 33280</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 2, 1996</b>   |   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Sunil Gupta, Johnson Heights Medical Building, Cumberland, MD 21502</b>  |   |   |  | 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>  |   |  |  |   |
|   |   |   |  | 32. Registrar's Signature<br>   |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 505A.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 21629

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mabel Hancock Outten</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 23 1996</b>   |  | 3. TIME OF DEATH<br><b>2:05 a m</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-16-9755</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/16/1903</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>5933 George Island Landing Road</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Stockton</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Worcester</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Worcester</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Stockton</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>5933 George Island Landing Road</b>   |  |
| 10f. ZIP CODE<br><b>21864</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Homemaker</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward Thomas Allen</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eva Lilliston</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jacqueline Mathias</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5933 George Island Landing Rd., Stockton, Md. 21864</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Portersville Methodist Cemetery 6/27</b>  |  | 20c. LOCATION — City or Town, State<br><b>Stockton, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott S. Maloney</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Melson Funeral Home<br/>PO Box 64, Pocomoke City, Md. 21851</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. cerebral vascular accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Patricia Maloney MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D46498</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/2/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Patricia Maloney MD 309 Timmons St. Snowhill Md</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 09 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. A. Anderson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21630

## Certificate of Death

Reg. No.

|  |  |  |   |   |  |  |   |  |
|--|--|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Sadie Fern Phillips</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>07 04 1996</b>  |  | 3. Time of Death<br><b>11:17 am</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Convalescent Center</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>286-24-6242</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>12-08-1902</b>                                    |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>VA</b>  |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Pasadena</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>1515 Park Lane</b>   |   | 10f. Zip Code<br><b>21122</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |   | 16b. Kind of Business/Industry<br><b>Home</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George Crowe</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lelia Butler</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria Kraus</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1515 Park Lane Pasadena MD 21122</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cem.</b>   |   | 20c. Date<br><b>7/8</b>  |  | 20d. Location - City or Town, State<br><b>Crownsville, MD</b>                               |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |   | 22. Name and Address of Facility<br><b>Barranco &amp; Sons Funeral Home<br/>495 Ritchie Hwy. Severna Park, MD 21146</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>Hypertension</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Sick sinus syndrome</b> |  |   |   |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28d. Describe how Injury occurred  |  |   |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| State Registrar  | 29b. Signature and title of certifier<br><b>Ram S. Karipine</b>  |  |   |   | 29c. License number<br><b>D26307</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/8/96</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RANI S. KARIPINE, 4000 ANNAPOLIS RD, Baltimore, MD 21227.</b>   |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>  |  |  |   | 32. Registrar's Signature<br><i>[Signature]</i> |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21631

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALDEN CLIFFORD PETERSON

2. Date of Death

Month 7 Day 1996

3. Time of Death

3:40 A.M.

4a. Facility Name (If not institution, give street and number)

MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death

Camp Springs MD

4c. County of Death

PRINCE GEORGES

5. Social Security Number

476-09-3286

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

November 5, 1919

9. Birthplace (State or Foreign Country)

MN

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Camp Springs

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7200 Easy Street

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Date 1943-1973

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired) Lt. Col.

Career Air Force

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Carl Oscar Peterson

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Bensen

19a. Informant's Name/Relationship (Type, Print)

Betty J. Peterson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7200 Easy Street Camp Springs, Maryland 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland State Veterans Cem.

Date

July 11, 1996

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc.  
6633 Old Alexandria Ferry Rd Clinton, Md 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

1 WEEK

b. RENAL FAILURE

Due to (or as a consequence of):

1 WEEK

c. DIABETES

Due to (or as a consequence of):

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

17128 AL

29d. Date signed (Month, Day, Year)

JULY 7 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL E COGHLAN, CAPT, USAF, MC

1050 W PERIMETER RD  
ANDREWS AFB MD 20762-6600

31. Date filed (Month, Day, Year)

JUL 0 9 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-0000.

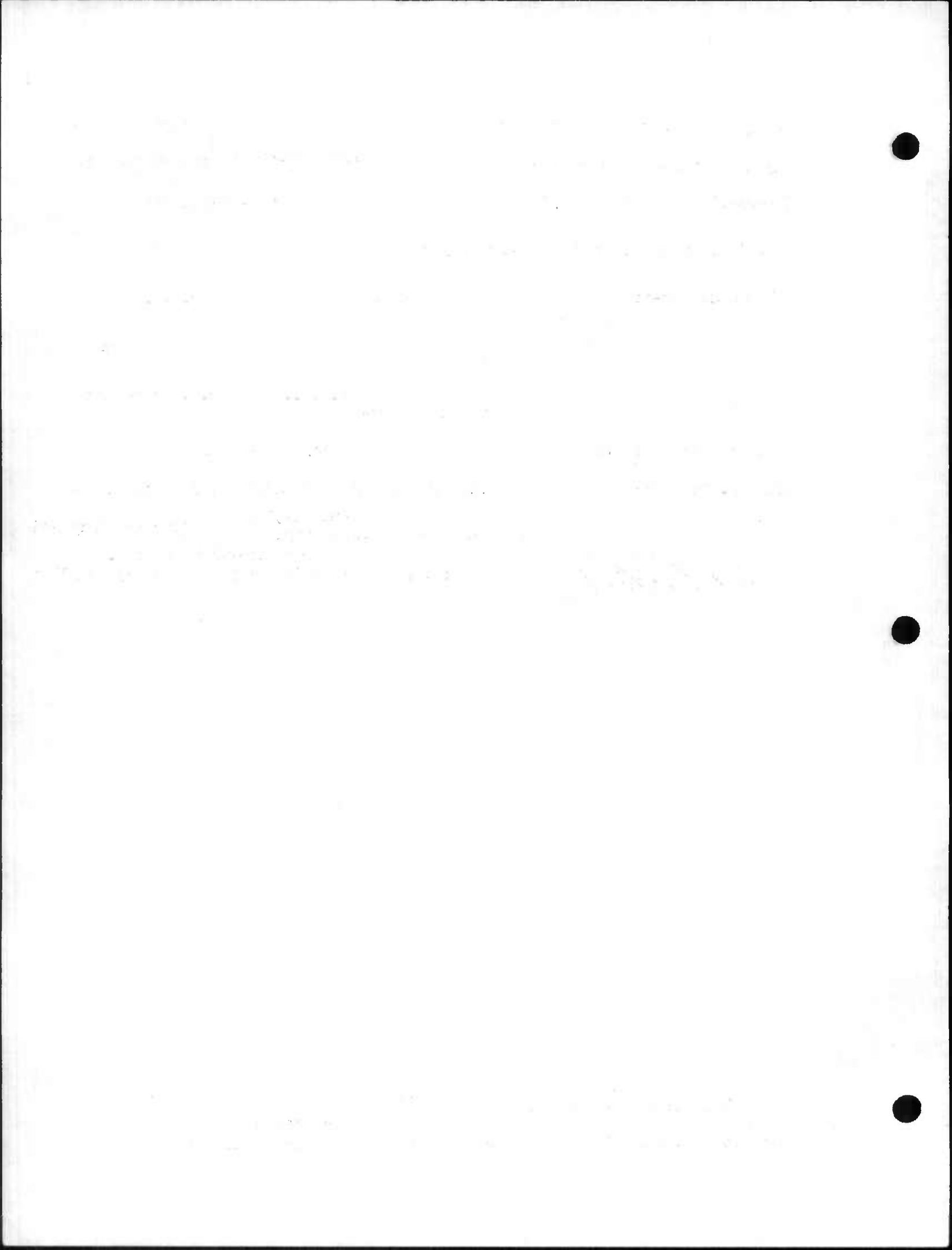
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21632

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ROY James Pennewell</b>                                     |   | 2. Date of Death<br>Month <b>July</b> Day <b>4</b> Year <b>1996</b> |  | 3. Time of Death<br><b>2116</b>        |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b> |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>            |  | 4c. County of Death<br><b>WICOMICO</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-226583</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.                    | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.         |
|   | 8. Date of Birth (Month, Day, Year)<br><b>2-5-28</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>         |  |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>WICOMICO</b>  |   | 10c. City, Town or Location<br><b>FRUITLAND</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |
| 10e. Street and Number<br><b>302 POPLAR STREET, APT. 101</b>  |  | 10f. Zip Code<br><b>21826</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b><br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CHICKEN GROWER</b>  |   | 16b. Kind of Business/Industry<br><b>POULTRY</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>FRANK PENNEWELL</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FLORENCE BRATTEN</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>NORA V. PENNEWELL/WIFE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>302 POPLAR STREET, APT. 101, FRUITLAND, MD 21826</b>  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SMULLEN CEMETERY</b>   |   | 20c. Location - City or Town, State<br><b>7/7/96 SAINT LUKES, MARYLAND</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>ZELLER FUNERAL HOME, P. O. BOX 3171,<br/>1212 OLD OCEAN CITY ROAD, SALISBURY, MD 21802</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)   |  | a. <b>VENTRICULAR FIBRILLATION</b>  |   | Approximate Interval Between Onset and Death<br><b>MIAS</b>  |  |
| Due to (or as a consequence of):  |  | b. <b>VENTRICULAR TACHY CARDIA</b>  |   | <b>MIAS</b>  |  |
| Due to (or as a consequence of):  |  | c. <b>ACUTE BRADYCARDIA</b>   |   | <b>MIAS</b>  |  |
| Due to (or as a consequence of):  |  | d.  |   |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS - YRS.</b>  |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>N/A</b>  |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury or Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D-04366</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>7/5/96</b>  |  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FRANK W. (ZELL) GOM M.D. 540 RIVERSIDE DR. SALISBURY, MD 21801</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL - 9 1996</b>  |  | 32. Registrar's Signature<br>   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at office.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21633

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Owen Claude PRICE   |  |   |  | 2. Date of Death<br>Month Day Year<br>July 5 96  |  | 3. Time of Death<br>7 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>901 Frederick Street  |  |   |  | 4b. City, Town, or Location of Death<br>Hagerstown   |  | 4c. County of Death<br>Washington   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>217-10-2749  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>78 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>March 9, 1918  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland  |  | 10b. County<br>Washington  |  | 10c. City, Town or Location<br>Hagerstown   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>901 Frederick Street  |  | 10f. Zip Code<br>21740   |  | 10g. Citizen of What Country?<br>U.S.A.   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1942-45   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) unknown  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>owner  |  | 16b. Kind of Business/Industry<br>tavern   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>George Price   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Edith Pauline Stull  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Ruth C. Price/Wife  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>901 Frederick Street, Hagerstown, Maryland 21740 |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Smithsburg Cemetery   |  | 20c. Location - City or Town, State<br>7-9-96 Smithsburg, Maryland   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>James T. Spier   |  | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 East Wilson Blvd., Hagerstown, Maryland 21740   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. gun shot wound, Head<br>Due to (or as a consequence of):<br>b. suicide<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death<br>sudden  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>History of depression and cancer  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |
|   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  |
|   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>Dr. Howard Weeks   |  | 29c. License number<br>D11266  |  | 29d. Date signed (Month, Day, Year)<br>July 6 96  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Washington County Hospital, Hagerstown, MD 21740  |  | 31. Date filed (Month, Day, Year)<br>JUL 08 1996  |  | 32. Registrar's Signature<br>John Anderson   |  | DR. HOWARD WEEKS  |  |



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21634

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lovell S. Queen

2. Date of Death

July 2 1996

Day Year

3. Time of Death

3:45 P.M.

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

216-78-8389

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

34

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAY 1 1962

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7946 FREETOWN ROAD

10f. Zip Code

21061

10g. Citizen of What Country?

US

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

BLACK

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HEALTH CARE PROVIDER

16b. Kind of Business/Industry

PAC PCA

17. Father's Name (First, Middle, Last)

HERBERT QUEEN

18. Mother's Name (First, Middle, Maiden Surname)

CONNIE GALLOWAY

19a. Informant's Name/Relationship (Type, Print)

HERBERT QUEEN (FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7946 FREETOWN RD. GLEN BURNIE, MD. 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JOHN WESLEY UM. CHURCH CEME.

7/8/96 WATERBURY, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Harry D. Reese

22. Name and Address of Facility

WM. REESE &amp; SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Auto immune deficiency Syndrome

Due to (or as a consequence of):

b. Human Immune deficiency Virus Infection

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. E. M. D.

29c. License number

D38958

29d. Date signed (Month, Day, Year)

7/3/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DALJEET SINGH SIDHU, 1413 ANNAPOLIS ROAD #106, ODENTON MD 21113

31. Date filed (Month, Day, Year)

JUL 09 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21635

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Ann Russell

2. Date of Death

Month Day Year

July 7, 1996

3. Time of Death

4:10 PM

4a. Facility Name (If not institution, give street and number)

90 Point Somerset Lane

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

302-42-4895

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 24, 1942

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

90 Point Somerset Lane

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12+

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Elementary School Teacher Education

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Ernest R. Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Smith

19a. Informant's Name/Relationship (Type, Print)

Mr. Craig P. Russell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

90 Point Somerset Lane Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lewes Presbyterian Cem. 7-11-96 Lewes, DE

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco &amp; Sons Funeral Home

495 Ritchie Hwy. Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Metastatic pancreatic cancer

Due to (or as a consequence of):

17 mos.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Ann C. Morley, M.D.

D44465

07/08/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ann C. Morley, M.D., 900 Bertgate Road, Suite 300, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JUL 12 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

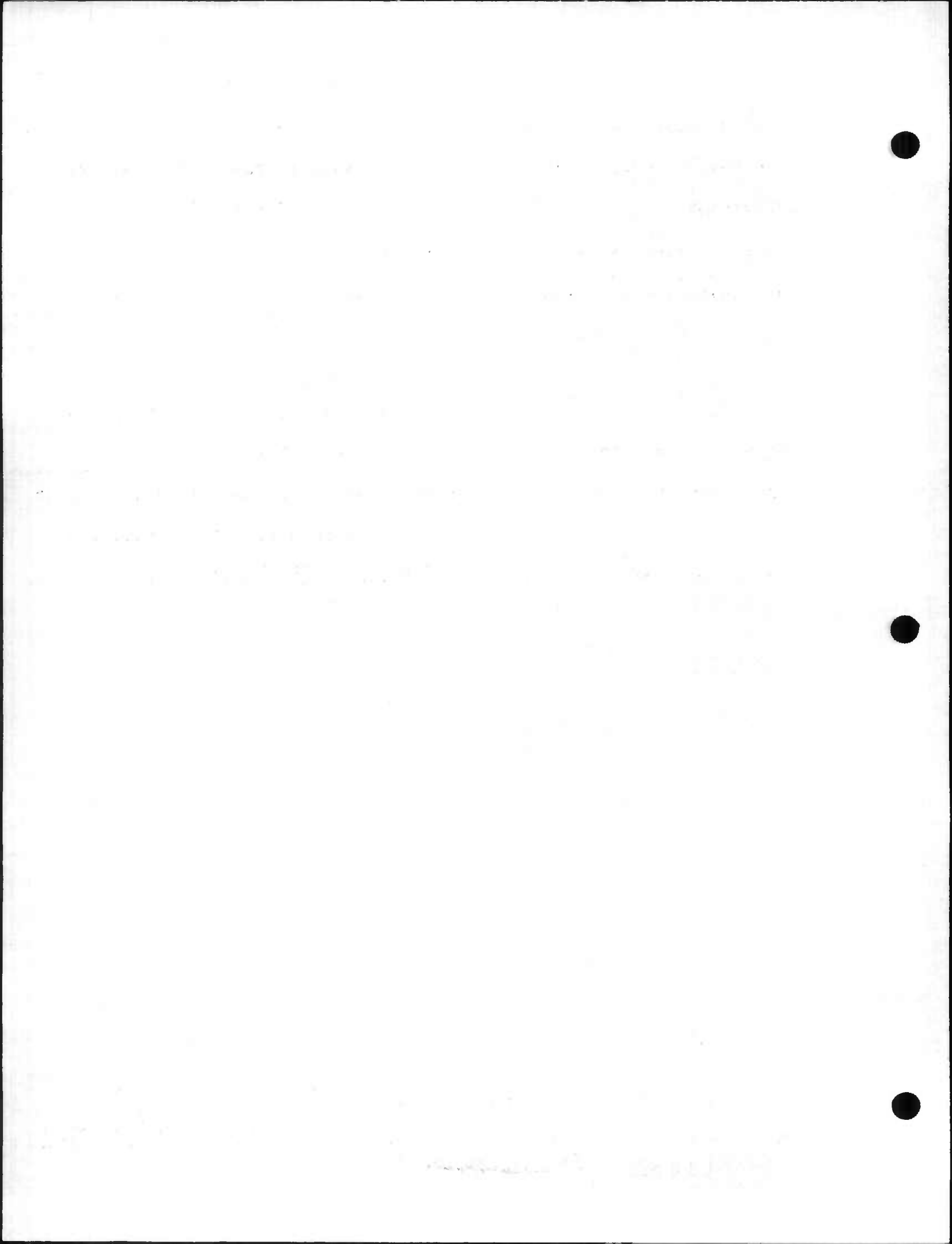
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 21636

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |  |   |  |
|---|--|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>EDWARD JOSEPH ROSENBLOOM, Sr.  |   |   |   | 2. Date of Death<br>Month Day Year<br>JULY 04, 1996  |  | 3. Time of Death<br>1842PM   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>2204 PINEFIELD ROAD  |   |   |   | 4b. City, Town, or Location of Death<br>WALDORF  |  | 4c. County of Death<br>CHARLES COUNTY  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>185-34-0088   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>51 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Jan 8, 1944   | 9. Birthplace (State or Foreign Country)<br>Windber, Pa       |  |
|   | Usual Residence of Decedent  |   |   |   |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |   | 10b. County<br>Charles  |   | 10c. City, Town or Location<br>Waldorf   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br>2204 Pinefield Road  |   |   |   | 10f. Zip Code<br>20603   |  | 10g. Citizen of What Country?<br>United States   |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12 5   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher                                  |   | 16b. Kind of Business/Industry<br>P.G. County School   |  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Harry Rosenbloom  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Isobel Amenta   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Victoria Rosenbloom  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7520 Snow Bell Lane, Clinton, Md 20735  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lee Crematory   |   | 20c. Location - City or Town, State<br>Clinton, Maryland   |  | 20d. Date<br>July 6, 1996  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Ray Goff</i>   |   |   |   | 22. Name and Address of Facility<br>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Contact gunshot wound of chest</i><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><i>UNK</i>   |   | 28b. Time of Injury<br><i>UNK</i> M       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><i>Subject shot self</i> |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Adam Lohend</i>   |   | 29c. License number<br>O.C.M.E.           |  | 29d. Date signed (Month, Day, Year)<br>JULY 05, 1996   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JASON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201  |  |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 09 1996  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general  
description of the project and its objectives.

2. The second part of the report is a detailed  
description of the methodology used in the study.

3. The third part of the report is a detailed  
description of the results of the study.

4. The fourth part of the report is a detailed  
description of the conclusions of the study.

5. The fifth part of the report is a detailed  
description of the recommendations of the study.

6. The sixth part of the report is a detailed  
description of the limitations of the study.

7. The seventh part of the report is a detailed  
description of the future research.

8. The eighth part of the report is a detailed  
description of the references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21637

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |  |  |
|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>SAMUEL Joseph RILEY</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 6 1996</b>  |  | 3. Time of Death<br><b>7:30 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>   |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>579-20-7324</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>March 2, 1913</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Mitchellville</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>10450 Lottsford Road Apt 247</b>  |  | 10f. Zip Code<br><b>20721</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Reserves</b><br>If Yes, Give Year or Dates:      |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Experimental Machinist/Teacher Naval Research Lab.</b> |  | 16b. Kind of Business/Industry  |  | 17. Father's Name (First, Middle, Last)<br><b>John Riley</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Tracy</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Samuel J. Riley, Jr.</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10514 Willetts Crossing Road White Plains MD 20695</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Clinton, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc.<br/>6633 Old Alexandria Ferry Rd Clinton, MD 20735</b>   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. SEPSIS</b><br>Due to (or as a consequence of):<br><b>b. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>1 week</b><br><b>1 week</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day Year)<br><b>N/A</b>   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |  |
|   | 29c. License number<br><b>001852</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 6, 1996</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL A. DEVORE MD 4203 QUEENSBURY RD HIGHTSTOWN NJ 08520</b>   |  | 31. Date filed (Month, Day, Year)<br><b>JUL 9 1996</b>   |  |
| State Registrar                               | 32. Registrar's Signature<br>   |  | 33. Date of Death (Month, Day, Year)<br><b>JUL 6 1996</b>  |  | 34. Date of Birth (Month, Day, Year)<br><b>MAR 2 1913</b>   |  | 35. Date of Death (Month, Day, Year)<br><b>JUL 6 1996</b>  |  |

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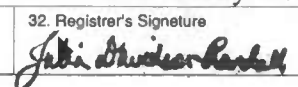
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Reg. No.

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| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>George Peabody ROWLAND, Jr.</b>                |  |  |   | 2. Date of Death<br>Month <b>07</b> Day <b>07</b> Year <b>96</b> |  | 3. Time of Death<br><b>0925</b>                             |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1120 Kenly Avenue #2</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>        |  | 4c. County of Death<br><b>Washington</b>                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>117-11-7712</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 17, 1910</b> | 9. Birthplace (State or Foreign Country)<br><b>Coraopolis, Pa.<br/>Steubenville, OH</b>  |
|  | Usual Residence of Decedent   |  |  |   | 10a. State<br><b>Maryland</b>                                    |  | 10b. County<br><b>Washington</b>                            |  |
| 10c. City, Town or Location<br><b>Hagerstown</b>   |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1120 Kenly Avenue #2</b>  |   | 10f. Zip Code<br><b>21740</b>  |
| 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>8</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>chemist</b>  |   | 16b. Kind of Business/Industry<br><b>tire and rubber</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>George P. Rowland</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Beacom</b>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Grace White Rowland /wife</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1120 Kenly Ave. #2, Hagerstown, Md. 21740</b>   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory</b>   |  | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  |  | 22. Name and Address of Facility<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>Left hemisphere cerebral thrombosis</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br><b>6-25-96</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |   |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   |  |
|  |   |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |   |  |
|  |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |  | 29b. Signature and title of certifier<br>  |  |  |   |  |
|  |   |  |  | 29c. License number<br><b>D111133</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 8, 1996</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Charles C. Spencer, M.D. 1198 Kenly Avenue, Hagerstown, Maryland 21740</b>  |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>  |   |  |  | 32. Registrar's Signature<br>  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



|  |   |  |  |  |   |  |   |  |
|--|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>PAULINE Mary RODMAN</b>  |  |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>15</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>3:45 PM.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Pineview Nursing Center</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>  |  | 4c. County of Death<br><b>Prince George's</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>002-24-8810</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 13, 1933</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Manchester N.H.</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Clinton</b>   |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>9106 Pinview Lane</b>  |  | 10f. Zip Code<br><b>20735</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+) <b>Collage</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Personel Clerk</b>   |  | 16b. Kind of Business/Industry<br><b>Treasury Dept.</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Peter Coughlin</b>  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Blanche Herbert</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mark Giddings</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4711 Leonardtown Road, Waldorf, Md 20602</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |
| Physician<br>/Medical<br>Examiner  | 20b. Piece of Disposition (Name of cemetery, crematory or other place)<br><b>St. Joseph Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Bedford, N.H.</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Charles L. Belanger</b>   |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735</b>  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CARDIAC ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| Division of Vital Records, P.O. Box 68760,   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PARKINSON'S DISEASE</b>  |  |  |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Theodore M. King</b>  |  |
| State Registrar  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 17, 1996</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 22 1996</b>   |  |
|  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

2

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

Page 2 of 2


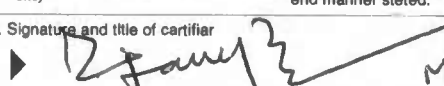

Amend # 1 & 2 Wash Co. Health Dept. LB July 9, 1996  
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21640

|   |  |  |   |  |   |  |  |   |  |  |
|---|--|--|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>X</b> Elizabeth<br><b>X</b> Geraldine <del>E.</del> Shingleton  |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br>July 4-96  |   | 3. Time of Death<br>10:09 AM   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>Avalon Manor Nursing Home  |  |   |  |   |  | 4b. City, Town, or Location of Death<br>Hagerstown   |   | 4c. County of Death<br>Washington  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>214-09-4247   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>78 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>April 11 1918   |   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent  |  |   |  |   |  |  |   |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland   |  | 10b. County<br>Washington   |  | 10c. City, Town or Location<br>Hagerstown   |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>542 Pangborn Blvd.   |  |   |  | 10f. Zip Code<br>21740  |  | 10g. Citizen of What Country?<br>U.S.A.  |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br>White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>unknown unknown  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cafeteria |   |  | 16b. Kind of Business/Industry<br>County Board of Education  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>George A. Churchey  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lela Harshman  |  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>George C. Shingleton / Son   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>542 Pangborn Blvd. Hagerstown, Md. 21740   |  |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hagerstown Crematory<br>Rest Haven Cemetery   |  | Data<br>7/5/96  |  | 20c. Location - City or Town, State<br>Hagerstown, Maryland  |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 E. Wilson Blvd. Hagerstown, Md. 21740   |  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ACUTE MYO CARDIAL INFARCTION<br>Due to (or as a consequence of):<br>b. CORONARY ARTERY DISEASE<br>Due to (or as a consequence of):<br>c. CONGESTIVE HEART FAILURE<br>Due to (or as a consequence of):<br>d. CARDIAC ARRHYTHMIAS |  |   |  |   |  |  |   |  |  |
|   | Approximate interval Between Onset and Death<br>4 HRS<br>NOT SURE<br>NOT SURE<br>NOT SURE  |  |   |  |   |  |  |   |  |  |
| Physician<br>/Medical<br>Examiner             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CEREBRO-VASCULAR ACCIDENT<br>RIGHT HEMIPARESIS<br>DYSPHAGIA WITH TUBE FEEDING  |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br> MD   |  |   |  |  |   |  |  |
|   | 29c. License number<br>D44996  |  | 29d. Date signed (Month, Day, Year)<br>June 4, 1996   |  |   |  |  |   |  |  |
| State<br>Registrar                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ZAFAR MALIK 20311 LAPPANS RD BOONSBORO MD 21713  |  |   |  |   |  |  |   |  |  |
|   | 31. Date filed (Month, Day, Year)<br>JUL 09 1996   |  | 32. Registrar's Signature<br>  |  |   |  |  |   |  |  |



96 21641

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Theodore Cecil Spence</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>06</b> DAY <b>25</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>4:05 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-26-8393</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 29, 1932 Maryland</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>8515 Liberty Town Road</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Berlin</b>   |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Worcester</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Berlin</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>8515 Liberty Town Road</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21811</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korean Conflict</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>African American</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>11th grade</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>laborer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Deer's Head Center</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Horace Robert Spence</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Minnie Tingle</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Bernyce Spence</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as above</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Bethel Cemetery 6/28</b>   |  | 20c. LOCATION — City or Town, State<br><b>Berlin, Maryland</b>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Patricia R. Jolley</i>  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Jolley Memorial Chapel MD 21801</b>   |  |  |  | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Lung Cancer (Squamous cell)</b><br><b>DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>6 mo</b> |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph N. Grasso MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 20507</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>6/27/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Joseph N. Grasso 145 E. CARROLL St SALISBURY MD</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUN 28 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson Randall</i>   |  |   |  |

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 6876

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5/1/96






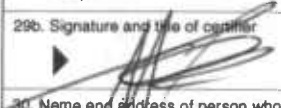

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21642

|   |  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM THEODORE SMITHERS</b>   |  |  |  | 2. Date of Death<br>Month <b>JUNE</b> Day <b>30</b> Year <b>1996</b>  |  |  |  | 3. Time of Death<br><b>1845</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |  |  |  | 4c. County of Death<br><b>WICOMICO</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>222-03-3658</b>  |  | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.  |  |
|   | 6. Date of Birth (Month, Day, Year)<br><b>3-2-1917</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>   |  | 10. Usual Residence of Decedent<br>10a. State <b>De.</b> 10b. County <b>Sussex</b> 10c. City, Town or Location <b>Delmar</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>103 E. Jewel St.</b>  |  | 10f. Zip Code<br><b>19940</b>   |  |
| To Be Completed by Funeral Director           | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Date: <b>1945-46</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>attendant</b>   |  | 16b. Kind of Business/Industry<br><b>Gas Station</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>William Smithers</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian (Maiden unknown)</b>   |  | 19. Informant's Name/Relationship (Type, Print)<br><b>Wm. Short</b>   |  |
| Physician<br>/Medical<br>Examiner             | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cem.</b>  |  | Date<br><b>7-3</b>  |  | 20c. Location - City or Town, State<br><b>Hurlock, Md.</b>   |  | 21. Signature of Funeral Service Licensee<br>   |  |
|   | 22. Name and Address of Facility<br><b>Short Funeral Home, Inc.<br/>13 E. Grove St. Delmar, De. 19940</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of): <b>CAD</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | Approximate Interval Between Onset and Death  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
| State Registrar                               | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D47637</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7-2-96</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Inzerillo, M.D. 3 Bi State Blvd. Delmar, Md. 21875</b>   |  | 31. Date filed (Month, Day, Year)<br><b>JUL 03 1996</b>   |  |
|   | 32. Registrar's Signature<br>   |  |  |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



96 21643

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Walter L. Sexton</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><u>July 2, 1996</u>   |  | 3. TIME OF DEATH<br>HOURS MIN.<br><u>3:15 A M</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>212-40-2988</u>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>67</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>2/18/1929</u>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><u>John Hopkins Bayview Med Ctr.</u>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore City</u>  |  | 8c. COUNTY OF DEATH<br><u>Baltimore City</u>  |  |
| 10a. STATE<br><u>MD</u>   |  | 10b. COUNTY<br><u>Anne Arundel</u>   |  | 10c. CITY, TOWN OR LOCATION<br><u>Severna Park</u>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><u>628 Kensington Ave.</u>  |  |  |  | 10f. ZIP CODE<br><u>21146</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) <u>2</u>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Manager</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Finance</u>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Walter L. Sexton, Sr.</u>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Doris Colbourn</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Mary L. Sexton</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>628 Kensington Ave. Severna Park MD 21146</u>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Metro Crematory 7/5</u>  |  | 20c. LOCATION — City or Town, State<br><u>Catonsville, MD</u>   |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>[Signature]</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Barranco &amp; Sons Funeral Home<br/>495 Ritchie Hwy Severna Park MD 21146</u>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Ruptured thoracic aorta</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval Between Onset and Death<br><u>5 months</u>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>stroke</u><br><u>Respiratory failure</u>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><u>Jan 25, 1996</u>  |  | 28b. TIME OF INJURY<br><u>9:12 A M</u>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><u>Automobile accident</u>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><u>street</u>  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><u>Arnold, MD<br/>Ritchie Hwy and College PKW</u>   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Dany Kayser MD</u>  |  |  |  | 29c. LICENSE NUMBER<br><u>D41617</u>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>July 2, 1996</u>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>10805 Hickory Ridge Rd. Columbia, MD 21044</u>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>JUL 10 1996</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21644

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Geraldine Natalie Strom

2. Date of Death  
Month Day Year

July 8, 1996

3. Time of Death

10:05 AM

4a. Facility Name (If not institution, give street and number)

220 McKinsey Rd.

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

5. Social Security Number

216-28-2507

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Sept. 28, 1933 Maryland

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

220 McKinsey Road

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12+

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. Do NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Edgar David Eigenbrode

18. Mother's Name (First, Middle, Maiden Surname)

Mary Barbara Kalista

19a. Informant's Name/Relationship (Type, Print)

Mr. Arvid Strom

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

220 McKinsey Road Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

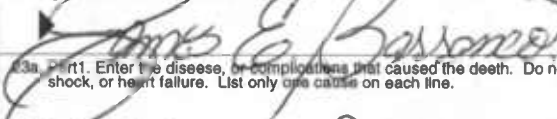
Loudon Park Cem. 7-11-96

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Barranco & Sons Funeral Home  
495 Ritchie Hwy. Severna Park, MD 2114623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIOMYOPATHY (END Stage)

Due to (or as a consequence of):

b. Rheumatic Heart Disease

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d. Chronic Obstructive Airway Disease

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

ME - 041216

29d. Date signed (Month, Day, Year)

7-10-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1204 West St. Annapolis, MD

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 1996

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

\_\_\_\_\_

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21645

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Everett G. Stook, Jr.

2. Date of Death

Month

Day

Year

3. Time of Death

1320

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

067-42-8394

6. Sex

XXM 20 F

7. Age (In yrs. last birthday)

45

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 6, 1951

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1X Yes 20 No

10e. Street and Number

15 Sunset Drive

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 11 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 2X No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12+

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Professor Business

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Everett George Stook, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice H. Stook

19a. Informant's Name/Relationship (Type, Print)

Mrs. Bonnie Stook

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Sunset Drive Severna Park, MD 21146

20a. Method of Disposition

10 Burial 2X Cremation 30 Removal from State  
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Date

7-12-1996

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Barranco & Sons Funeral Home  
495 Ritchie Hwy. Severna Park, MD 2114623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

METASTATIC CARCINOMA Colon To Liver

Approximate  
Interval Between  
Onset and Death

8 months

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 2X No 30 Probably 40 Unknown

24a. Was an autopsy  
performed?

10 Yes 2X No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

10 Yes 20 No

25. Was case referred to medical  
examiner?

10 Yes 2X No

Hospital:

1X Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

1X Natural 50 Pending Investigation  
20 Accident 60 Could not be determined  
30 Suicide 40 Homicide28a. Date of Injury  
(Month, Day, Year)

M

28b. Time of  
Injury

M

28c. Injury at  
Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D22777

29d. Date signed (Month, Day, Year)

7/8/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John W. Maffray, M.D.; 703 Groddings Ave., Suite L-3  
Annapolis, Md.  
21401

31. Date filed (Month, Day, Year)

JUL 12 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





96 21646

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Lynn Edward Sipe, Jr.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>3</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>12:45 P M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-58-8545</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>45</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5-29-1951</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>33 Sunset Drive</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Severna Park</b>  |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |   |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Severna Park</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>33 Sunset Drive</b>   |  | 10f. ZIP CODE<br><b>21146</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+) <b></b>  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Broker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Insurance</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lynn E. Sipe, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Lange</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edward Sipe, III</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>33 Sunset Drive Severna Park, MD 21146</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glen Haven</b>   |  | 20c. LOCATION — City or Town, State<br><b>1884 Glen Burnie, MD</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James E. Carson</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Barranco &amp; Sons Funeral Home<br/>495 Ritchie Hwy Severna Park, MD 21146</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Non-Hodgkin's lymphoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b></b><br>b. <b></b><br>c. <b></b><br>d. <b></b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>5 mo.</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b></b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b></b>  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b></b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b></b>  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b></b>   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ann C. Massey, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D44465</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/5/96</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ann C. Massey, M.D., 900 Bestgate Road, Annapolis, MD 21401</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 12 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

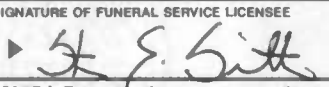
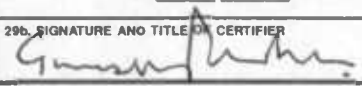
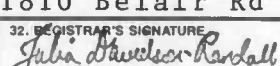
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 21647

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Peter William Schmitz Jr.</b>  |  | 2. DATE OF DEATH<br><b>July 02</b> DAY 1996 YEAR   |  | 3. TIME OF DEATH<br><b>2:17</b> P M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-40-9561</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  |
| 7. DATE OF BIRTH<br><b>Feb. 5, 1914</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Milwaukee, WI</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harford Memorial Hospital.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Havre de Grace</b>   |  | 9c. COUNTY OF DEATH<br><b>Harford</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Harford</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Havre de Grace</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>1325 Superior Street</b>   |  | 10f. ZIP CODE<br><b>21078</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1943-1945</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE - American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerk</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Federal Trade Commission</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Peter William Schmitz, Sr.</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edith Perry</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Raymond D. Schmitz (Son)</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 188 Accokeek, Md. 20607</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cemetery</b>   |  | 20c. LOCATION - City or Town, State<br><b>Cheltenham, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lee Funeral Home, Inc.<br/>6633 Old Alexandria Ferry Rd Clinton, Md 20735</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular Disease</b>  |  |  |  |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br>DME   |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>July 02, 1996  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>G.S. Prabhu M.D. 1810 Belair Rd # 102 Fallston MD. 21047 410-879-6564</b>   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 09 1996  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21648

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>James Monroe Shorter</b>  |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>3</b> Year <b>1996</b>  |  |  |  | 3. Time of Death<br><b>7:00 pm</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Dorchester General Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Cambridge</b>   |  |  |  | 4c. County of Death<br><b>Dorchester</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-42-9088</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 19, 1945</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | 10a. State<br><b>Maryland</b>  |  |   |  | 10b. County<br><b>Dorchester</b>   |  | 10c. City, Town or Location<br><b>Cambridge</b>                                  |  |  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>5302 Spring Drive</b>   |  |   |  | 10f. Zip Code<br><b>21613</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1964</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Air Traffic Controller</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Transportation</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Granville S. Shorter</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Murial E. Airey</b>  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Murial E. Shorter/Mother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5302 Spring Drive, Cambridge, MD. 21613</b>  |  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD. Veterans Cemetery 7-8</b>  |  | 20c. Location - City or Town, State<br><b>Hurlock, MD.</b>   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>James E. Curran</i>  |  |   |  | 22. Name and Address of Facility<br><b>Curran-Bromwell Funeral Home, P.A.<br/>308 High St., Cambridge, MD. 21613</b>   |  |  |  |  |  |
|   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. <i>Chronic liver</i></b><br>Due to (or as a consequence of):<br><b>b. <i>Alcoholic Liver Disease</i></b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  | Approximate interval between Onset and Death<br><b>5 yrs</b><br><b>5 yrs</b>   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b><i>Hypertension</i></b><br><b><i>Adult onset Diabetes</i></b>   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |  |  |
|   |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><i>Michael Feldman</i>   |  | 29c. License number<br><b>226388</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7-9-96</b>                             |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael Feldman MD 302 Collins Hurlock MD 21643</b>   |  |   |  |  |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUL 9 1996</b>   |  | 32. Registrar's Signature<br><i>John Davidson Randall</i>   |  |  |  |  |  |  |  |



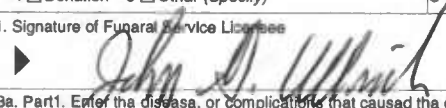
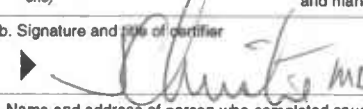
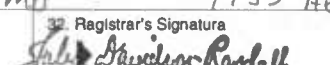
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Département of Health and Mental Hygiene

96 21649

## Certificate of Death

Reg. No.

|  |   |  |  |  |  |   |  |  |  |  |
|--|---|--|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HAROLD R. SCHAEFFER</b>  |  |  |  | 2. Date of Death<br>Month <b>07</b> Day <b>06</b> Year <b>96</b>   |   | 3. Time of Death<br><b>1948 hrs</b>  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ATLANTIC GENERAL HOSPITAL</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BERLIN</b>  |   | 4c. County of Death<br><b>WORCESTER</b>  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>188-05-5295</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.         | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>6-13-19</b>  | 9. Birthplace (State or Foreign Country)<br><b>PA.</b> |  |  |
|  | Usual Residence of Decedent   |  |  |  | 10a. State<br><b>MD.</b>   |   | 10b. County<br><b>WORCESTER</b>  |  |  |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br><b>BERLIN</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>73 BOSTON DRIVE</b>   |  |  |  |
|  | 10f. Zip Code<br><b>21811</b>   |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |  |  |  |
|  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MACHINIST</b>  |   | 16b. Kind of Business/Industry<br><b>TOOL &amp; DIE</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>FRANKLIN SCHAEFFER</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Margaret Jean Thornberg</b>  |   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>M. SUSAN SCHAEFFER</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5024 OCEAN PINES BERLIN, MD., 21811</b>  |   |  |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SALISBURY CREMATORY</b>   |   | 20c. Location - City or Town, State<br><b>7-8 SALISBURY, MD.</b>   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>ULLRICH FUNERAL HOME BERLIN, MD.</b>  |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Coronary Artery Disease.</b><br>Dua to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Dua to (or as a consequence of):</b><br><b>c. Dua to (or as a consequence of):</b><br><b>d.</b> |  |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>years</b> |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD.</b>  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>                          |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred  |  |  |  |   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |  |
| 29b. Signature and Title of certifier<br>   |   | 29c. License number<br><b>00050605</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 6, 96</b> |  |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN CHRISTIE MD 9733 Healthway Dr, Berlin, MD 21811</b>  |   |  |  |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>  |   | 32. Registrar's Signature<br>   |  |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





96 21650

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Blenda Elton Stottlemeyer</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 8, 1996</b>   |  | 3. TIME OF DEATH<br><b>8:40 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 14 5882</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 23, 1900</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Reeders Memorial Home</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Boonsboro</b>   |  | 9c. COUNTY OF DEATH<br><b>Washington</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1036 Marshall Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>housekeeping</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>nursing</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward W. Marteney</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Virgie Gimple</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dawn V. Schaff</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>112 Morning Side Drive Winchester, Virginia 22601</b>                                       |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Funkstown Cemetery 7/11</b>   |  | 20c. LOCATION — City or Town, State<br><b>Funkstown, Maryland</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald N. Minnich</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Renal failure</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Congestive Heart Failure</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Arteriosclerotic Cardiovascular disease</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>2-3 days</b><br><b>1 week</b><br><b>2 years</b> |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypothyroidism Senile Dementia</b>  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D18015</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 9, 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Vasant Datta 334 Mill Street, Hagerstown, Maryland 21740 1-301-739-7100</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 11 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 21651

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DOROTHY JUNE STINE   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>JULY 7 1996   |  | 3. TIME OF DEATH<br>3:15 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-18-8986   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>JUNE 6, 1921   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>IOWA   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>COLTON VILLA NURSING CENTER  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>HAGERSTOWN   |  | 9c. COUNTY OF DEATH<br>WASHINGTON   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>WASHINGTON  |  | 10c. CITY, TOWN OR LOCATION<br>BOONSBORO  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>21403 MT. LENA ROAD  |  |  |  | 10f. ZIP CODE<br>21713  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (14 or 5+) 8  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HEEL PRESSER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>SHOE MANUFACTURING  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JESSE M. STINE  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>GLADYS PRUDENE BENSON  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>VIRGINIA CROW  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13009 LOY WOLFE ROAD, SMITHSBURG, MD 21783   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT. LENA CEMETERY 7/10/96   |  | 20c. LOCATION — City or Town, State<br>MT. LENA, MARYLAND   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Paul M. Dean  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>BAST FUNERAL HOME 7606 Old National Pike Boonsboro, MD 21713  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Cardiovascular disease to lower<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>Fright Cerebrovascular accident<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DM Type II - Insulin requiring   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE NOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature] M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D44131   |  | 29d. DATE SIGNED (Month, Day, Year)<br>7/7/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br>Henry L. Corrales, M.D. 750 Dual Hwy. Hagerstown MD   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 08 1996   |  | 32. REGISTRAR'S SIGNATURE<br>John [Signature]  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21652

|   |   |  |   |   |   |                                |   |  |
|---|---|--|---|---|---|--------------------------------|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>CYNTHIA LOU SIMPSON   |  |   |   | 2. Date of Death<br>Month Day Year<br>JUNE 30 1996  |                                | 3. Time of Death<br>1048 A  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>105 MITCHELL ST.  |  |   |   | 4b. City, Town, or Location of Death<br>ELKTON  |                                | 4c. County of Death<br>CECIL  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>212-80-7470  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>33 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>April 10, 1963   |  |
|   | Usual Residence of Decedent   |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |   |   |                                |   |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland  |  | 10b. County<br>Cecil  |   | 10c. City, Town or Location<br>Elkton   |                                |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br>109 Milestone Road  |  |   |   | 10f. Zip Code<br>21921  |                                | 10g. Citizen of What Country?<br>United States  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br>12  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Waitress                                 |   | 16b. Kind of Business/Industry<br>Restaurant  |                                |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Delmon James Gooslin   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dorothy Deyton   |                                |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Matthew T. Simpson/Husband  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>109 Milestone Road, Elkton, Maryland 21921   |                                |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Elkton Cemetery   |   | 20c. Location - City or Town, State<br>Elkton, Maryland   |                                | 20d. Date<br>July 3, 1996   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>James S. Hicks</i>  |  |   |   | 22. Name and Address of Facility<br>Hicks Home for Funerals, P.A.<br>103 W. Stockton St., Elkton, Maryland 21921  |                                |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Hanging</i><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |                                |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |   |                                |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |   |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br>June 6/30/96  |   | 28b. Time of Injury<br>1047 A.M.  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred<br>Subject hanged self  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br>105 Mitchell Street<br>Elkton, Maryland                               |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>105 Mitchell Street<br>Elkton, Maryland   |                                |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |                                |   |  |
| State Registrar                               | 29b. Signature and title of certifier<br><i>Theodore M. King</i>  |  |   |   | 29c. License number<br>O.C.M.E  |                                | 29d. Date signed (Month, Day, Year)<br>JULY 01, 1996  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Theodore M. King 111 Penn Street, Baltimore, Maryland 21201   |  |   |   |   |                                |   |  |
|   | 31. Date filed (Month, Day, Year)<br>JUL 08 1996  |  |   |   | 32. Registrar's Signature<br><i>Chia Davidson-Rendall</i>   |                                |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21653

Reg. No.

|  |   |   |   |  |  |   |   |   |   |  |
|--|---|---|---|--|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Frances Dawn Swartz</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>July, 7 1996</b>  |   | 3. Time of Death<br><b>1:30 AM</b>  |   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Charles County Nursing Center</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>La Plata</b>  |   | 4c. County of Death<br><b>Charles</b>   |   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-50-3921</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 16, 1937</b>   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>   |   |  |
|  | Usual Residence of Decedent   |   |   |  |  |   |   |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Charles</b>   |  | 10c. City, Town or Location<br><b>Waldorf</b>  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |
|  | 10e. Street and Number<br><b>4536 C Reeves Place</b>  |   |   |  | 10f. Zip Code<br><b>20601</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Merchandiser</b>                |  | 16b. Kind of Business/Industry<br><b>Department Store Woodward &amp; Lothrop</b>   |   |   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Benjamin Nelson</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances H. Vaicekauskas</b>  |   |   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Debra Sargent-Daughter</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3216 Bethesda Dr., Waldorf, Maryland 20601</b>   |   |   |   |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Trinity Memorial</b>   |  | Data<br><b>7/11/96</b>   |   | 20c. Location - City or Town, State<br><b>Waldorf, Maryland</b>   |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b> M-00174   |   |   |  | 22. Name and Address of Facility<br><b>AREHART-ECHOLS FUNERAL HOME, INC.<br/>P.O. Box 567, La Plata, Md. 20646</b>   |   |   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. LUNG CANCER</b><br><br>Due to (or as a consequence of):<br><b>b. METASTATIC</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |   |   |   | Approximate Interval Between Onset and Death<br><b>6m</b> |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |  |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |   |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>                  |  | 28c. Injury at work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |   | 28d. Describe how injury occurred   |   |  |
|  |   | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   |  |  | 29c. License number<br><b>D28352</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>7-8-96</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Krishian M. Mathur, MD P.O. Box 1703, La Plata, Maryland 20646</b>  |   |   |   |  |  |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 1996</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |   |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 21654

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |   |  |  |
|---|--|---|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>EARL MORRIS</b>   |   | (SNEADE)<br><b>SNEADE</b>   |   | 2. Date of Death<br>Month Day Year<br><b>JULY 3, 1996</b>  |   | 3. Time of Death<br><b>0057</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |   | 4c. County of Death<br><b>WICOMICO</b>   |  |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>215-36-1256</b>  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 13, 1933</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Somerset</b>   |   | 10c. City, Town or Location<br><b>Rhodes Point</b>   |  |
| To Be Completed by Funeral Director                     | 10e. Street and Number<br><b>3395 Marsh Road</b>   |   | 10f. Zip Code<br><b>21824</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 10</b><br>College (1-4or 5+) <b>---</b>  |   | 16. Kind of Business/Industry<br><b>Marine Fuel</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Maurice W. Sneade</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lena Marsh</b>   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lena M. Sneade (mother)</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3395 Marsh Road - Rhodes Point, MD 21824</b>      |   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rhodes Point Cemetery</b>   |  |
|   | 20c. Date<br><b>7/7/96</b>   |   | 20d. Location - City or Town, State<br><b>Rhodes Point, MD</b>  |   | 21. Signature of Funeral Service Licensee<br><b>Robert H. Bradshaw</b>   |   | 22. Name and Address of Facility<br><b>Bradshaw &amp; Sons Funeral Home<br/>306 W. Main St. - Crisfield, MD 21817</b>  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   | Approximate Interval Between Onset and Death<br><b>1 year</b>   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                 |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>James E. Martin, M.D.</b>  |  |
|   | 29c. License number<br><b>030690</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 3, 1996</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD.</b>   |   | 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>  |  |
| 32. Registrar's Signature<br><b>John A. [Signature]</b> |  | 33. Registrar's Signature<br><b>John A. [Signature]</b> |   | 34. Registrar's Signature<br><b>John A. [Signature]</b> |  | 35. Registrar's Signature<br><b>John A. [Signature]</b> |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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State of Maryland / Department of Health and Mental Hygiene

96 21655

Certificate of Death

Reg. No.

|  |  |  |   |   |  |   |  |   |   |
|--|--|--|---|---|--|---|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>IONA MAE STAKEM</b>   |  |   |   | 2. Date of Death<br>Month <b>JUNE</b> Day <b>29</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>10:00AM</b>   |   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |   | 4c. County of Death<br><b>Allegany</b>   |   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-07-4193</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>March 29, 1911</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |
|  | Usual Residence of Decedent  |  |   |   |  |   |  |   |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Allegany</b>  |   | 10c. City, Town or Location<br><b>Midland</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |
|  | 10e. Street and Number<br><b>19817 Big Lane</b>  |  |   |   | 10f. Zip Code<br><b>21542</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>   |  | 16b. Kind of Business/Industry<br><b>Hotel</b>  |  |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Claude L. Ward</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Duckworth</b>   |  |   |  |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patrick Stakem</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8816 Churchfield Lane, Laurel, Md. 20708</b>   |   |  |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Josephs Cemetery</b>   |   | Date<br><b>July 1, 1996</b>  |   | 20c. Location - City or Town, State<br><b>Midland, Md.</b>   |   |   |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |   | 22. Name and Address of Facility<br><b>Eichhorn-McKenzie Funeral Home<br/>Lonaconing, Md. 21539</b>  |   |  |   |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>20 yrs</b> |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>advance peripheral vascular Disease</b>   |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |
|  |  |  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day Year)                                      |   | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      |  | 28d. Describe how injury occurred   |   |
|  |  |  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                          |  |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |   |  |   |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |  |   | 29c. License number<br><b>D11443</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 01, 1996</b>   |  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Wayne Spiggle, 912 Seton Dr. Cumberland, MD 21502</b>   |  |  |   |   |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 03 1996</b>  |  |  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21656

## Certificate of Death

Reg. No.

|  |  |   |  |   |   |  |  |  |
|--|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HAZEL JANE SPICHER</b>                      |   |  |   | 2. Date of Death<br>Month Day Year<br><b>July 5, 1996</b> |  | 3. Time of Death<br><b>12:15 am</b>                        |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b> |  | 4c. County of Death<br><b>Allegany</b>                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-12-2142</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.          |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 12, 1920</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>                                      |   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Allegany</b>                            |  | 10c. City, Town or Location<br><b>Cumberland</b>           |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>603 Greenway Avenue</b>  |   | 10f. Zip Code<br><b>21502</b>  |  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Former Clerk</b>                  |   | 16b. Kind of Business/Industry<br><b>Social Security</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Earl Ford Spicher</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lena Cecelia (Baumann)</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Spicher--sister</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>603 Greenway Avenue; Cumberland, MD 21502</b> |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Blooming Rose Cemetery</b>   |  | 20c. Date<br><b>07/07</b>   |   | 20d. Location - City or Town, State<br><b>Friendsville, MD</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home<br/>Cumberland, MD 21502</b>  |   |  |  |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Aspiration pneumonia</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |   |  |  |  |
| Approximate Interval Between Onset and Death<br><b>2 days</b>  |  |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease, chronic congestive heart failure</b>   |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 28d. Describe how Injury occurred  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D 14865</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 5, 1996</b>   |  |  |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print)<br><b>Dr. R. Barrera, Memorial Hospital Medical Bldg., Cumberland, MD 21502</b>   |  |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 1996</b> Registered Signature<br>  |  |   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



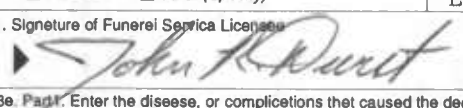
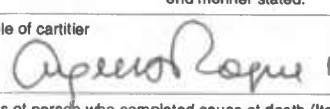
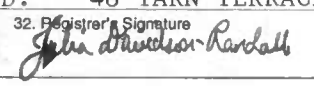
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21657

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MARY WINIFRED SLEEMAN  |  |   |  | 2. Date of Death<br>Month JULY Day 6, Year 1996  |  | 3. Time of Death<br>07:24 A.M.   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>SACRED HEART HOSPITAL  |  |   |  | 4b. City, Town, or Location of Death<br>CUMBERLAND   |  | 4c. County of Death<br>ALLEGANY  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-01-0345   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>97 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>DECEMBER 18, 1898                             |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MARYLAND   |  | 10b. County<br>ALLEGANY   |  | 10c. City, Town or Location<br>ECKHART MINES   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>10032 PARKERSBURG ROAD   |  |   |  | 10f. Zip Code<br>21528   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4<br>College (1-4 or 5+) 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SEAMSTRESS                               |  | 16b. Kind of Business/Industry<br>MANUFACTURING  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>J. CHARLES CARTER   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>NELLIE CONNOR   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>DR. H. KENNETH SLEEMAN   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>813 BALTIMORE ROAD ROCKVILLE, MARYLAND 20851  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ECKHART CEMETERY  |  | Date<br>JULY 9, 1996   |  | 20c. Location - City or Town, State<br>ECKHART, MARYLAND   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>DURST FUNERAL HOME<br>57 FROST AVENUE FROSTBURG, MARYLAND 21532  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. CONGESTIVE HEART FAILURE<br>Due to (or as a consequence of):<br>b. A S C V D<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.                  |  |   |  |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br> |   | 29c. License number<br>D 13166   |  | 29d. Date signed (Month, Day, Year)<br>JULY 8, 1996                                  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ANGEL ROQUE M.D. 48 TARN TERRACE FROSTBURG, MARYLAND 21532  |  |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 08 1996  |  |  |   | 32. Registrar's Signature<br> |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is devoted to a general survey of the situation in the country.

2. The second part of the report is devoted to a detailed analysis of the economic situation.

3. The third part of the report is devoted to a detailed analysis of the social situation.

4. The fourth part of the report is devoted to a detailed analysis of the political situation.

5. The fifth part of the report is devoted to a detailed analysis of the cultural situation.

6. The sixth part of the report is devoted to a detailed analysis of the environmental situation.

7. The seventh part of the report is devoted to a detailed analysis of the international situation.

8. The eighth part of the report is devoted to a detailed analysis of the future prospects.

9. The ninth part of the report is devoted to a detailed analysis of the conclusions.

10. The tenth part of the report is devoted to a detailed analysis of the recommendations.

11. The eleventh part of the report is devoted to a detailed analysis of the annexes.

12. The twelfth part of the report is devoted to a detailed analysis of the bibliography.

13. The thirteenth part of the report is devoted to a detailed analysis of the index.

14. The fourteenth part of the report is devoted to a detailed analysis of the appendices.

15. The fifteenth part of the report is devoted to a detailed analysis of the maps.

16. The sixteenth part of the report is devoted to a detailed analysis of the tables.

17. The seventeenth part of the report is devoted to a detailed analysis of the figures.

18. The eighteenth part of the report is devoted to a detailed analysis of the charts.

19. The nineteenth part of the report is devoted to a detailed analysis of the diagrams.

20. The twentieth part of the report is devoted to a detailed analysis of the photographs.

21. The twenty-first part of the report is devoted to a detailed analysis of the films.

22. The twenty-second part of the report is devoted to a detailed analysis of the sound recordings.

23. The twenty-third part of the report is devoted to a detailed analysis of the documents.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21658

Reg. No.

|   |  |   |  |   |  |  |  |  |
|---|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>HERMAN ALBERT SNOOTS</b>                        |   |  |   | 2. Date of Death<br>Month Day Year<br><b>JULY 06, 1996</b> |  | 3. Time of Death<br><b>2100 P</b>  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>SACRED HEART HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>  |  | 4c. County of Death<br><b>ALLEGANY</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-10-7351</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>July 8, 1920</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent  |   |  |   |  |  |  |  |
| 10a. State<br><b>WV</b>   |  | 10b. County<br><b>MINERAL</b>   |  | 10c. City, Town or Location<br><b>FT. ASHBY</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>ROUTE 28</b>   |  |   |  | 10f. Zip Code<br><b>26719</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRAIN MASTER</b>  |  | 16b. Kind of Business/Industry<br><b>RAILROAD</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>WILLIE WILLIAM SNOOTS</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FELICIA GRANDELL</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ELEANOR SNOOTS</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 673 - FT. ASHBY, WV 26719</b>  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SUNSET MEMORIAL PARK</b>   |  | Data<br><b>7/9/96</b>   |  | 20c. Location - City or Town, State<br><b>CUMBERLAND, MD</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>George Upchurch</i>   |  |   |  | 22. Name and Address of Facility<br><b>GEORGE-UPCHURCH FUNERAL HOME, P.A.<br/>202 GREENE ST., CUMBERLAND, MD 21502</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Endstage Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br><br>b. _____ Due to (or as a consequence of):<br><br>c. _____ Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>3 mos</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                            |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><i>John P. Nelson</i>  |  | 29c. License number<br><b>D222181</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 07, 1996</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WAGONER, GARY, M.D. 925 BISHOP WELSH ROAD CUMBERLAND, MD. 21502</b>  |  |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>   |  |   |  | 32. Registrar's Signature<br><i>John P. Nelson</i>  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21659

Amended #1, 7/9/96,  
NHS, Allegany CountyPhysician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

STEPHAN S. SCHOENADEL

2. Date of Death

Month 7 Day 7 Year 96

3. Time of Death

9:20 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

5. Social Security Number

214-46-3218

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) May 19, 1949

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

LaVale

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

25 Martz Lane

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: Viet Nam

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner/operator

16b. Kind of Business/Industry

D &amp; S Distributors

17. Father's Name (First, Middle, Last)

William Schoenadel

18. Mother's Name (First, Middle, Maiden Surname)

Ethel (Jewell)

19a. Informant's Name/Relationship (Type, Print)

Deborah Schoenadel--wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 Martz Lane; LaVale, MD 21502

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SS Peter Paul Cemetery

Date

07/10

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

END STAGE INTERSTITIAL LUNG DISEASE

Due to (or as a consequence of):

Pleuritis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Pulmonary Emboli

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Renee Green, M.D.

29c. License number

N2704

29d. Date signed (Month, Day, Year)

7/8/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

600 N. Wolfe Street / Dept of Pathology Johns Hopkins Hospital

31. Date filed (Month, Day, Year)

JUL 09 1996

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21660

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |   |   |  |  |  |  |
|---|---|--|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM VICTOR SMITH</b>   |  |  |  |  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>06</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>08:31 AM</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>  |  |  |  |  |   | 4b. City, Town, or Location of Death<br><b>cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b>   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-14-6044</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 16, 1922</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |
|   | Usual Residence of Decedent   |  |  |  |  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Allegany</b>   |  | 10c. City, Town or Location<br><b>Lonaconing</b> |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |   | 10e. Street and Number<br><b>49 church street</b>   |  | 10f. Zip Code<br><b>21539</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>      |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>emergency Management State</b>   |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>State</b>   |  |  |  |  |   | 16b. Kind of Business/Industry  |  | 17. Father's Name (First, Middle, Last)<br><b>John Victor Smith</b>  |  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jennie Vamps</b>  |  |  |  |  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Burton Smith / Brother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>49 church ST. Lonaconing, Md. 21539</b>  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Restlawn Mem. Gardens</b>   |  | 20c. Location - City or Town, State<br><b>LaVale, Maryland</b>   |   | 21. Signature of Funeral Service Licensee<br><b>James E. McKenzie</b>   |  | 22. Name and Address of Facility<br><b>Eichhorn-McKenzie Funeral Home - 8 East Main ST. Lonaconing, Md. 21539</b>  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cor pulmonale</b>   |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>1 year</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  |  |
|   | 28b. Time of Injury<br><b>M</b>   |  |  |  |  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |
| 29b. Signature and title of certifier<br><b>Richard G. Settnuth MD</b>  |   |  |  |  |  | 29c. License number<br><b>D26333</b>                    |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 8, 1996</b> |  |  |  |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><b>900 setm Drive Cumberland Md 21502</b> |   |  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b> |   | 32. Registrar's Signature<br><b>John A. ...</b>            |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21661

## Certificate of Death

Reg. No.

|  |   |  |   |                                |  |
|--|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>CLAYTON OLIVER</b>   |  | 2. Date of Death<br>Month <b>June</b> Day <b>28</b> Year <b>1996</b>  |                                | 3. Time of Death<br><b>0917</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |                                | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>222-22-8195</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 7, 1937</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>SELBYVILLE, DE</b>   |                                |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent   |  |   |                                |  |
|  | 10a. State<br><b>DE</b>   | 10b. County<br><b>SUSSEX</b>   | 10c. City, Town or Location<br><b>DAGSBORO</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>RD# 1 BOX 197A</b>   |  | 10f. Zip Code<br><b>19939</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)   |                                |  |
|  | 16. Kind of Business/Industry<br><b>POULTRY</b>   |  | 17. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MECHANIC</b>   |                                |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>TRAVELLA McCABE</b>   |  | 19. Father's Name (First, Middle, Last)<br><b>WALTER TOWNSEND</b>   |                                |  |
|  | 19a. Intment's Name/Relationship (Type, Print)<br><b>MRS. BETTY LOU TOWNSEND</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD# 1 BOX 197 A, DAGSBORO, DELAWARE 19939</b>   |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DAGSBORO REDMEN MEM. CEM.</b>  |                                | 20c. Location - City or Town, State<br><b>7/1/96 DAGSBORO, DELAWARE</b>  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>MELSON FUNERAL SERVICES, LTD. FRANKFORD, DELAWARE 19945</b>  |                                |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CARDIO MYOCLASIS</b><br>Due to (or as a consequence of):<br><b>b. CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Due to (or as a consequence of): |  |   |                                | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                                |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |  |
|  | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
| State Registrar  | 29. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |  |
|  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D38353</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>6-28-96</b>  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Rene Desmarais M.D. 560 Riverside Dr. B101 Salisbury Md.</b>   |  |   |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 01 1996</b>              |   | 32. Registrar's Signature<br>  |   |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

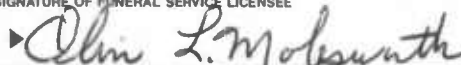

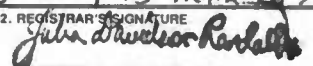




96 21662

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mabel Agnes Tregoning</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>July</b> DAY <b>6</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>1414 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-50-2278</b>  |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 18, 1909</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Germantown</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO                      |  |
| 10e. STREET AND NUMBER<br><b>23701 Ridge Road</b>  |  |  |  | 10f. ZIP CODE<br><b>20876</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>American</b>   |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>10</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own home.</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Garrett Webster Watkins</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Vertie A. Mullinix</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John M. Tregoning - Husband</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23701 Ridge Road, Germantown, Maryland 20876</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Salem Cemetery</b>   |  | 20c. LOCATION - City or Town, State<br><b>7/9 Germantown, Maryland</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Olin L. Molesworth, P.A., Funeral Home</b><br><b>26401 Ridge Road, Damascus, Maryland 20872</b> |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>CARDIAC ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | Approximate Interval Between Onset and Death<br><b>minutes</b>   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  | b. <b>RESPIRATORY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | <b>5 minutes</b>   |  |
|  |  | c. <b>SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | <b>10 DAYS</b>   |  |
|  |  | d. <b>PERFORATED BOWEL</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | <b>10 DAYS</b>   |  |
|  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                                     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>DO</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>H41818</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7-8-96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Patrick Sterling DO 9815 main St. Damascus MD. 20872</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 08 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21663

|  |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>ANTONINA V. WRIGHT TURNER                |   |  |   | 2. Date of Death<br>Month Day Year<br>JULY 5 1996 |   | 3. Time of Death<br>5:15PM   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>116 SILOPANNA ROAD |   |  |   | 4b. City, Town, or Location of Death<br>ANNAPOLIS |   | 4c. County of Death<br>ANNE ARUNDEL  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-22-1449   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>68 Yrs.         |   | 8. Date of Birth (Month, Day, Year)<br>OCT. 5 1927   |  |  |
|  | 10a. State<br>MARYLAND   |   | 10b. County<br>ANNE ARUNDEL  |   | 10c. City, Town or Location<br>ANNAPOLIS          |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| To Be Completed by Funeral Director                                  |  | 10e. Street and Number<br>116 SILOPANNA ROAD  |  |   |   | 10f. Zip Code<br>21403  |  | 10g. Citizen of What Country?<br>US  |  |
|  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK   |  |
|  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12th lyr.   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>NURSE                                    |   | 16b. Kind of Business/Industry<br>CROWNSVILLE STATE HOSPITAL  |  |  |  |
|  |  | 17. Father's Name (First, Middle, Last)<br>FIDEL CORNEL   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>LOTTIE HASTE   |  |  |  |
|  |  | 19a. Informant's Name/Relationship (Type, Print)<br>ANGELIQUE KNOX (GRANDDAUGHTER)  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6533 E. JEFFERSON AVE. LOFT 108J detriot, Michigan 396 48207   |  |  |  |
|  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ANNAPOLIS MEM. GARDENS  |   | 20c. Location - City or Town, State<br>ANNAPOLIS, MD.   |  | 20d. Date<br>7/11/96   |  |
|  |  | 21. Signature of Funeral Service Licensee<br>Larry H. Reese   |  |   |   | 22. Name and Address of Facility<br>WM. REESE & SONS MORTUARY, P.A.<br>821 WEST ST. ANNAPOLIS, MD. 21401  |  |  |  |
|  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Metastatic colon carcinoma to lung 3 yrs.<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |  |  |  |
| Physician<br>/Medical<br>Examiner                                    |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  |  | 28d. Describe how Injury occurred   |  |   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   | 29b. Signature and title of certifier<br>Michael Hamilton MD<br>NCI-NAVA MEDICAL ONCOLOGY INC.  |  |  |  |
|  |  | 29c. License number<br>D25893   |  |   |   | 29d. Date signed (Month, Day, Year)<br>9 JUL 96 1500  |  |  |  |
|  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>J. MICHAEL HAMILTON, MD, NCI; NMMC BLOOMSBURY MEDICAL   |  |   |   |   |  |  |  |
| State<br>Registrar   |  | 31. Date filed (Month, Day, Year)<br>JUL 11 1996  |  |   |   | 32. Registrar's Signature<br>Julia Davidson-Randall   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21664

|   |   |  |   |                                 |  |
|---|---|--|---|---------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ARTHUR GRAHAM TILLET</b>   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>5</b> Year <b>1996</b>   |                                 | 3. Time of Death<br><b>12:25 P.M.</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7706 LOCRIIS DRIVE</b>   |  | 4b. City, Town, or Location of Death<br><b>UPPER MARLBORO</b>   |                                 | 4c. County of Death<br><b>PRINCE GEORGES</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>229-38-2372</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Sept 3, 1936</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |                                 |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |                                 |  |
|   | 10e. State<br><b>Maryland</b>   | 10b. County<br><b>Prince George's</b>  | 10c. City, Town or Location<br><b>Upper Marlboro</b>  |                                 | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>7706 Locris Drive</b>  |  | 10f. Zip Code<br><b>20772</b>   |                                 | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |                                 |  |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Line Shop Supervisor</b>   |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>   |                                 |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Derwood Tillett</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Bibb</b>   |                                 |  |
|   | 19. Informant's Name/Relationship (Type, Print)<br><b>Myrtle L. Tillett</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7706 Locris Drive, Upper Marlboro, Md 20772</b>   |                                 |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |                                 | 20c. Location - City or Town, State<br><b>Brentwood Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735</b>  |                                 |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Arteriosclerotic Cardiovascular Disease</b>  |  |   |                                 | Approximate Interval Between Onset and Death   |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |                                 |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                 | 24e. Was an autopsy performed?<br><b>INSPECTION</b><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |                                 |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                 |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b> | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| State Registrar   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Donald G Wright MD</b>  |                                 | 29c. License number<br><b>O.C.M.E.</b>   |
|   | 29d. Date signed (Month, Day, Year)<br><b>JULY 6, 1996</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DONALD G WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>  |                                 |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 9 1996</b>  |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>                     |   |                                 |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 21665

## Certificate of Death

Reg. No.

|  |   |  |   |                                       |   |   |   |  |
|--|---|--|---|---------------------------------------|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MABEL ARLENE TOTTEN</b>  |  |   |                                       | 2. Date of Death<br>Month Day Year<br><b>JULY 5, 1996</b>   |   | 3. Time of Death<br><b>0950</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>33 WEST GEORGE ST.</b>   |  |   |                                       | 4b. City, Town, or Location of Death<br><b>WESTMINSTER</b>  |   | 4c. County of Death<br><b>CARROLL</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-16-1895</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>75 Yrs.</b>  |   | 8. Date of Birth (Month, Day, Year)<br><b>4/29/1921</b>                                     |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>PA.</b>  |  | 10a. State<br><b>MD.</b>  |                                       | 10b. County<br><b>CARROLL</b>   |   | 10c. City, Town or Location<br><b>WESTMINSTER</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>33 WEST GEORGE ST.</b>   |                                       | 10f. Zip Code<br><b>21157</b>   |   | 10g. Citizen of What Country?<br><b>USA.</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> Collage (1-4 or 5+) <b>7</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DIETARY</b>                       |                                       | 16b. Kind of Business/Industry<br><b>HEALTH</b>   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>HARVEY MYERS</b>  |  |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ADA GEESEY</b>  |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DENNIS TOTTEN</b>  |  |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11916 TARRAGON RD., REISTERSTOWN, MD. 21136</b>   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MEADOW BRANCH CEM.</b>   |                                       | Date<br><b>7/8/96</b>   |   | 20c. Location - City or Town, State<br><b>WESTMINSTER, MD.</b>                              |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |                                       | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME<br/>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>  |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Ventricular Fibrillation</b><br>Due to (or as a consequence of):<br><b>b. Acute myocardial infarction</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Systemic Hypertension, Congestive Heart Failure</b> |  |   |                                       |   |   |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |                                       |   |   |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                       |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |                                       |   |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                       | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |                                       | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred   |  |   |                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |                                       | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |
| 29b. Signature and title of certifier<br>  |   |  |   | 29c. License number<br><b>D182000</b> |   | 29d. Date signed (Month, Day, Year)<br><b>7/18/96</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)   |   |  |   |                                       |   |   |   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>JUL 9 1996</b>  |  |   |                                       | 32. Registrar's Signature<br>   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

96 21666

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Ellsworth TAYLOR

2. Date of Death

Month Day Year  
July 9, 1996

3. Time of Death

5:45 pm

4a. Facility Name (If not institution, give street and number)

326½ E. Franklin Street

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

214-36-1331

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 25, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

326½ E. Franklin Street

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

warehouse manager

16b. Kind of Business/Industry

food warehouse

17. Father's Name (First, Middle, Last)

Harold Elwood Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Edna Metz

19a. Informant's Name/Relationship (Type, Print)

Vickie Noll

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

841 Summit Avenue, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hagerstown Crematory

Date

7-10-96

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

MINNICH FUNERAL HOME  
415 E. Wilson Blvd., Hagerstown, Md. 2174023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Abdominal lymphoma  
Due to (or as a consequence of):Approximate  
interval Between  
Onset and Death

1 year.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D46473

29d. Date signed (Month, Day, Year)

7/10/96

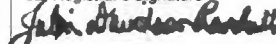
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown MD 21740

31. Date filed (Month, Day, Year)

JUL 10 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

1972-1973

1974-1975

1976-1977

1978-1979

1980-1981

1982-1983

1984-1985

1986-1987

1988-1989

1990-1991

1992-1993

1994-1995

1996-1997

1998-1999

2000-2001

2002-2003

2004-2005

2006-2007

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21667

|   |   |   |  |  |  |  |   |   |
|---|---|---|--|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Matthew Joseph Tucker</b>                |   |  |  | 2. Date of Death<br>Month <b>JUNE</b> Day <b>29</b> Year <b>1996</b> |  | 3. Time of Death<br><b>0315</b>   |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Union Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>                |  | 4c. County of Death<br><b>Cecil</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>none</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>June 29, 1996</b>                             | 9. Birthplace (State or Foreign Country)<br><b>Elkton, MD</b> |
|   | Usual Residence of Decedent   |   |  |  |  |  |   |   |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Elkton</b>   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>28 N. Navaho Trail</b>   |   |   |  | 10f. Zip Code<br><b>21921</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                 |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> Collage (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>never worked</b>   |  |  | 16b. Kind of Business/Industry<br><b>never worked</b>                                   |   |
| 17. Father's Name (First, Middle, Last)<br><b>John B. Tucker, Jr.</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Reta Torrance</b>  |  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John B. Tucker, Jr. (father)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>28 N. Navaho Trail Elkton, MD 21921</b>  |  |  |   |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. 1 Saints Cemetery</b>  |  | Date<br><b>7/3/96</b>  |  | 20c. Location - City or Town, State<br><b>Wilm., DE</b>  |   |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |  | 22. Name and Address of Facility<br><b>McCrery Funeral Homes, Inc.<br/>3924 Concord Pike Wilm., De. 19803</b>  |  |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>PRENATALITY - 24 wks.</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |  |  |  |   | Approximate interval Between Onset and Death<br><b>1 hr.</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |
|   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred                             |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br><i>[Signature]</i> <b>Physician - Pediatrician</b>   |  | 29c. License number<br><b>B-21038</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>6-29-96</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Elsa Leonardo M.D. 719 Bridge St Elkton, Md 21921</b>  |   |   |  |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 1996</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i> <b>Julia Davidson-Rodalle</b>   |  |  |  |  |   |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



96 21668

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE SOLOMON TULL</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 6, 1996</b>  |  | 3. TIME OF DEATH<br><b>6:30 a. M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-34-7606</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 12, 1912</b>                              |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Edw. W. McCready Memorial Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Crisfield</b>                                     |  |
| 9c. COUNTY OF DEATH<br><b>Somerset</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  |   |  |
| 10b. COUNTY<br><b>Somerset</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Marion Station</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |
| 10e. STREET AND NUMBER<br><b>6270 Charles Cannon Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21838</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>(White)</b>   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 7</b><br>College (1-4 or 5+) <b>---</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Farming</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Tull</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Manie Crosswell</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marion L. Tull (wife)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6270 Charles Cannon Road - Marion Station, MD 21838</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>St. Paul's Cemetery 7/9/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Marion Station, MD</b>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert H. Bradshaw</b>                      |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Bradshaw &amp; Sons Funeral Home<br/>306 W. Main St. - Crisfield, MD 21817</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Bilateral Bronchopneumonia</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>Mediastinal Cyst</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Constrictive Heart Failure</b> |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William Gill MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D15715</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7.6.96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WILLIAM GILL MD, BURTON AVE, CRISFIELD, MD 21817</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 9 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Anderson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(100-100000)

Jan. 12, 1942

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Section 100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21669

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLIFTON

LEE

Todd

2. Date of Death

Month

Day

Year

3. Time of Death

1810

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

213-24-1139

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

12/19/1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

SOMERSET

10c. City, Town or Location

DAMES QUARTER

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11409 HUDSON WHITE ROAD

10f. Zip Code

21820

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: KOREAN

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WATERMAN

16b. Kind of Business/Industry

SEAFOOD

17. Father's Name (First, Middle, Last)

DENWOOD H. TODD

18. Mother's Name (First, Middle, Maiden Summa)

EFFIE J. TODD

19a. Informant's Name/Relationship (Type, Print)

DENWOOD H. TODD/BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2502 BOND STREET, SALISBURY, MD. 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TODD & WHITE CEMETERY

Date

7/6/96

20c. Location - City or Town, State

DAMES QUARTER, MD.

21. Signature of Funeral Service Licensee

*James L. Morris* MO0295

22. Name and Address of Facility

HINMAN FUNERAL HOME

11673 SOMERSET AVENUE, PRINCESS ANNE, MD. 21853

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

End Stage Pul Ca (Squamous Cell Ca)

Due to (or as a consequence of):

b.

Resp failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of causa of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

29b. Signature and title of certifier

*Dr. Julio M. De Pena*

29c. License number

048221

29d. Date signed (Month, Day, Year)

7/5/96

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dr. JULIO M. DE PEÑA 262 TILGHMAN RD SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

JUL 08 1996

32. Registrar's Signature

*John Michael Randall*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





96 21670

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dorothy Viola Turkington</b>   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 6, 1996</b>                                       |  | 3. TIME OF DEATH<br><b>10:45P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>199-28-7851</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>92 YRS.</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>September 8, 1903</b>                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Kansas</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>25246 Smith Landing Road</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Denton</b>  |  | 9c. COUNTY OF DEATH<br><b>Caroline</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Caroline</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Denton</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER<br><b>25246 Smith Landing Road</b>   |  |  |  |   |  | 10f. ZIP CODE<br><b>21629</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Caucasian</b>                  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dr. John Bitting Smith Norton</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gertrude Havens</b>                     |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Paul Turkington nephew</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6015 Old Trappe Road, Trappe, Maryland 21673</b>  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Denton Cemetery</b>   |  | DATE<br><b>7/9</b>  |  | 20c. LOCATION — City or Town, State<br><b>Denton, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Handwritten Signature</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Moore Funeral Home, P.A.<br/>PO Drawer B, Denton, Maryland 21629</b>   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Dementia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |   |  |   |  | Approximate interval Between Onset and Death<br><b>years</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Decubitus Ulcers</b>   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Handwritten Signature</i>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D31376</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7-8-96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James Sikes 920 Market St Denton MD</b>   |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>9-9-96</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Handwritten Signature</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21671

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Frances Vandevort

2. Date of Death  
Month Day Year

July 8, 1996

3. Time of Death

4:00 AM

4a. Facility Name (If not institution, give street and number)

453 Shore Acres Road

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

190-24-3120

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

12/27/31

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

453 Shore Acres

10f. Zip Code

21012

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Sales Associate

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

George

F.

Knox

18. Mother's Name (First, Middle, Maiden Surname)

Hilda

Appelt

19a. Informant's Name/Relationship (Type, Print)

Robert C. Vandevort

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16106 Alderwood Lane, Bowie, Md. 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Memorial Gardens 7-12

Data

20c. Location - City or Town, State

Davidsonville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St., Annapolis, Maryland 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic breast cancer

Approximate Interval Between Onset and Death

4 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter R. Graze, MD, 900 Bestgate Rd. #300, Annapolis, MD 20715

31. Date filed (Month, Day, Year)

JUL 09 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21672

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL COLE WHIPP

2. Date of Death

Month Day Year  
JULY 06 1996

3. Time of Death

10:43AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

214-16-7664

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 6 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Poolesville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

P.O. Box 237

10f. Zip Code

20837

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

brick layer

16b. Kind of Business/Industry

construction

17. Father's Name (First, Middle, Last)

William W. Whipp

18. Mother's Name (First, Middle, Maiden Surname)

Mamie A. Cole

19a. Informant's Name/Relationship (Type, Print)

Brenda Testerman/granddaughter 18613 Wasche Rd. Dickerson, MD 20842

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Monocacy

Date

7/9

20c. Location - City or Town, State

Beallsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hilton Funeral Home  
Barnesville, MD 2083823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *myocardial infarction*  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

HOURS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *Coronary Artery Disease*  
Due to (or as a consequence of):

3 YEARS

c. *chronic Renal Failure*  
Due to (or as a consequence of):

YEARS

d. *Hypertension*  
Due to (or as a consequence of):

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D44571

29d. Date signed (Month, Day, Year)

July 6, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. JAMES L. COCKRELL

31. Date filed (Month, Day, Year)

JUL 08 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

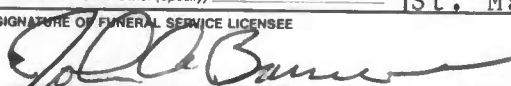
Medical Certification: To Be Completed by Physician/Medical Examiner



96 21673

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mildred Keenan Williams</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 4, 1996</b>  |  | 3. TIME OF DEATH<br><b>7:00 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-34-4332</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 13 1913 MD</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>  |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Annapolis</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                  |  |
| 10e. STREET AND NUMBER<br><b>22 Maryland Ave.</b>  |  |   |  | 10f. ZIP CODE<br><b>21401</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Albert Keenan</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence Mildred Glorius</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara Smith</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 Admiral Rd. Severna Park, MD. 21146</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Margaret's Cemetery 7/8 Annapolis, MD</b>  |  | 20c. LOCATION — City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Barranco &amp; Sons Funeral Home<br/>495 Ritchie Hwy. Severna Park MD 21146</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Myocardial Infarction</b> <b>Five minutes</b><br>DU TO (OR AS A CONSEQUENCE OF):<br>b.<br>DU TO (OR AS A CONSEQUENCE OF):<br>c.<br>DU TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>July 4, 1996</b>  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
|  |  |   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>David C. Barron</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D52469</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 5, 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David C. Barron 800 Westpark Road Annapolis Md.</b>  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 12 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Mathematics, 1958 - 1960



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21674

Certificate of Death

Reg. No.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Peggy M WARD</b>   |   | 2. Date of Death<br>Month <b>July</b> Day <b>1</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>2015</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |  | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>229-54-6957</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>3-20-42</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   | 10c. City, Town or Location   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10a. State<br><b>Virginia</b>   | 10b. County<br><b>Accomack</b>  | <b>Assawoman</b>  |  |  |
|  | 10e. Street and Number  |   | 10f. Zip Code<br><b>23302</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Specialist</b>  |
|  | 16b. Kind of Business/Industry<br><b>Dept. of Navy</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Brooks T Mears</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ellouise Bloxom</b>  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Fred J. Ward, Jr. (Spouse)</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Assawoman, VA 23302</b>                       |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Assawoman Cemetery</b>   |  | Date<br><b>7-5-96</b>  |
|  | 20c. Location - City or Town, State<br><b>Assawoman, VA</b>   |   | 21. Signature of Funeral Service Licensee<br><b>James H. Fox</b>  |  | 22. Name and Address of Facility<br><b>Fox Funeral Home, PO Box 278, Temperanceville, VA 23442</b>   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>metastatic Colon Cancer</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>4 mo</b> |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day Year)   |   | 28b. Time of injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 28d. Describe how injury occurred  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br><b>Joseph N. Grasso</b>  |   | 29c. License number<br><b>D 20507</b>  | 29d. Date signed (Month, Day, Year)<br><b>7/2/96</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph N. GRASSO 145 E. CARROLL ST SALISBURY MD</b>   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 03 1996</b>  |   | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21675

|  |  |   |  |  |   |   |  |  |   |   |  |
|--|--|---|--|--|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>VIRGINIA L. WYSZYNSKI</b>                       |   |  |  |   |   | 2. Date of Death<br><b>JULY 07, 1996</b>   |  | 3. Time of Death<br><b>0940 AM</b>                          |   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b> |   |  |  |   |   | 4b. City, Town, or Location of Death<br><b>CUMBERLAND</b>                                      |  | 4c. County of Death<br><b>ALLEGANY</b>                      |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217 14 4581</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>72</b>     |   | 8. Date of Birth (Month, Day, Year)<br><b>MAY 31, 1924</b>                                     |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |   |  |
|  | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>ALLEGANY</b>   |  | 10c. City, Town or Location<br><b>FROSTBURG</b> |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No              |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+)  |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEMOTHER</b> |  | 16b. Kind of Business/Industry<br><b>HOME FOR RETARDED CHILDREN</b>  |   |   |  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>LAWRENCE WINEBRENNER</b>   |  |   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FLORA MARTENS</b>   |  |  |   |   |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>ROBERTA McGUIRE</b>   |  |   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>62 W. MECHANIC ST., FROSTBURG, MD 21532</b>   |  |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CUMBERLAND CREMATORY</b>  |   | 20c. Location - City or Town, State<br><b>7/8/96 CUMBERLAND, MD 21502</b>   |  |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Marlene M. Sowers</i>  |  |   |  |  |   | 22. Name and Address of Facility<br><b>SOWERS FUNERAL HOME, P.A.<br/>60 W. MAIN ST., FROSTBURG, MD 21532</b>  |  |  |   |   |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |   |   |  |  |   | Approximate Interval Between Onset and Death  |  |
| Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):   |  |   |  |  |   |   |  |  |   | 4 DAYS  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. <b>ASCVD</b><br>Due to (or as a consequence of):   |  |   |  |  |   |   |  |  |   | 10 yrs.   |  |
| c. <b>Rt lower lobe pneumonia</b><br>Due to (or as a consequence of):  |  |   |  |  |   |   |  |  |   | > days  |  |
| d.   |  |   |  |  |   |   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |   |   |  |  |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  |   |  |  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  | 28e. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred   |  |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |   | 29b. Signature and title of certifier<br><i>Angela H. Roque MD</i>  |  | 29c. License number<br><b>D13166</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 8, 1996</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ANGEL H. ROQUE MD 48 TARD Terrace, Frostburg, Md 21532</b>  |  |   |  |  |   |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b> Registrar's Signature<br><i>John A. ...</i>  |  |   |  |  |   |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21676

|   |  |  |   |   |  |   |  |   |  |
|---|--|--|---|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Amanda Jacqueline ELLIOTT a.k.a. Sandra Zimmerman  |  |   |   | 2. Date of Death<br>Month Day Year<br>July 5, 1996   |   | 3. Time of Death<br>4:30pm   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Carroll County General Hospital  |  |   |   | 4b. City, Town, or Location of Death<br>Westminster  |   | 4c. County of Death<br>Carroll   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>216-11-3430   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>56 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>May 20, 1940   | 9. Birthplace (State or Foreign Country)<br>Maryland   |   |  |
|   | Usual Residence of Decedent  |  |   |   |  |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |  | 10b. County<br>Frederick  |   | 10c. City, Town or Location<br>Frederick   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br>5744 Etzler Road   |  |   |   | 10f. Zip Code<br>21702   |   | 10g. Citizen of What Country?<br>U.S.A.  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Attorney                                 |   |  |   | 16b. Kind of Business/Industry<br>Law  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Harry Elias ZIMMERMAN Jr  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lucy Margaret FORD  |   |  |   |  |
| Physician<br>/Medical<br>Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br>Mrs. Gina Frierman/Daughter  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5744 Etzler Road, Frederick, Maryland, 21702  |   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt Olivet Cemetery July 9, 1996   |   | 20c. Location - City or Town, State<br>Frederick, Maryland   |   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Keith Lynn Robinson</i> M00706   |  |   |   | 22. Name and Address of Facility<br>Keeney & Basford P.A. Funeral Home<br>106 East Church St., Frederick, Maryland 21701   |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Arteriosclerotic cardiovascular disease 1 day with acute myocardial infarction</i><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |  | 28d. Describe how injury occurred   |  |
|   |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br><i>Ali J. Afrookteh</i>  |  |  |   | 29c. License number<br>D35183   |  | 29d. Date signed (Month, Day, Year)<br>July 8, 1996   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Ali J. Afrookteh, M.D., 300 West Ninth Street, Frederick, Maryland 21701  |  |  |   |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 08 1996  |  |  |   | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21677

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |   |                                |  |  |
|--|--|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Louis Henry ATWELL</b>  |  |   |  | 2. Date of Death<br><b>July 20, 1996</b>  |                                | 3. Time of Death<br><b>9:18 AM</b>   |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>Doctors Comm. Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |                                | 4c. County of Death<br><b>PG</b>   |  |
| 5. Social Security Number<br><b>578-07-2630</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Jul 29 1918</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |   |  |   |                                |  |  |
| Usual Residence of Decedent  |  |   |  |   |                                |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George</b>   |  | 10c. City, Town or Location<br><b>Hyattsville</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>6000 42nd Avenue</b>  |  |   |  | 10f. Zip Code<br><b>20781</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br><b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>   |                                | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William F. Atwell</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Effie Bast</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Henry Atwell</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6000 42nd Ave, Hyattsville, Md 20781</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodfield Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Galesville, Md</b>  |                                | 20d. Date<br><b>7/23/96</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.,<br/>905 Galesville Rd., Galesville, Md 20765</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiorespiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. Coronary artery disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Severe peripheral Vascular disease</b> |  |   |  |   |                                |  |  |
| Approximate Interval Between Onset and Death<br><b>Sudden arrest</b><br><b>Several years</b>   |  |   |  |   |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe peripheral Vascular disease</b>  |  |   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |   |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |                                |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |                                |  |  |
| 29b. Signature and title of certifier<br><b>Bruce M. Lowman</b>  |  |   |  | 29c. License number<br><b>D18189</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>7/20/96</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>BRUCE LOWMAN 7223 HANOVER PKY, GREENBELT, md 20770</b>  |  |   |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b shows any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar





7/23/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21678

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Gertrude I. Aldrich</b>  |   | 2. Date of Death<br>Month <b>July</b> Day <b>18</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>9:30 AM</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5717 Edmondson Avenue Apt. 102-B</b>   |   | 4b. City, Town, or Location of Death<br><b>Catonsville</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director  | 5. Social Security <b>214-20-1078</b> Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 12, 1904</b>   |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   |   |  |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent   |   |   |  |  |
|  | 10a. State<br><b>Md.</b>  | 10b. County<br><b>Baltimore</b>                 | 10c. City, Town or Location<br><b>Catonsville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>5717 Edmondson Avenue Apt. 102-B</b>   |   | 10f. Zip Code<br><b>21228</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph McKenny</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cliff Aldrich (Son)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3 Country Club Phoenix, Maryland 21131</b>  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   | 22. Name and Address of Facility<br><b>Witzke Funeral Home Inc.<br/>1630 Edmondson Avenue Catonsville, Maryland</b>   |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Respiratory failure</b><br>Due to (or as a consequence of):<br>b. <b>Malignant lymphoma</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>7 months</b><br><b>7 months</b> |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive heart failure</b><br><b>Chronic obstructive lung disease</b>  |   |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| State Registrar  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |
|  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>028236</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 19 1996</b>   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dorian St Martin 5411 Old Frederick Rd Balt MD 21229</b>   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>              |   | 32. Registrar's Signature<br><i>[Signature]</i> |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Page 2 of 2

The first part of the document discusses the importance of maintaining accurate records of all transactions. It is essential for the company to have a clear and concise system in place to ensure that all data is properly recorded and stored. This will help in the future when it comes to analyzing the data and making informed decisions.

In the second part, we will look at the various methods used to collect and analyze data. It is important to choose the right method for the job, as different methods can provide different levels of accuracy and detail. For example, using a survey to collect data might be more appropriate for a large group of people, while using a focus group might be better for a smaller, more targeted group.

The third part of the document focuses on the importance of data security. With so much data being collected and stored, it is crucial to ensure that it is protected from unauthorized access. This can be done through a variety of methods, including encryption, firewalls, and secure storage. It is also important to have a clear policy in place regarding data security, and to ensure that all employees are aware of and follow this policy.

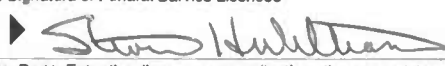
Finally, the document discusses the importance of data analysis. Once the data has been collected and stored, it is essential to analyze it in order to gain insights into the company's performance and make informed decisions. This can be done through a variety of methods, including statistical analysis, data visualization, and machine learning. It is important to choose the right method for the job, and to ensure that the analysis is done in a clear and concise manner.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21679

## Certificate of Death

Reg. No.

|   |  |   |  |   |  |  |  |  |
|---|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EVELYN I. BAUGHAN</b>   |   |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1996</b> |  | 3. Time of Death<br><b>7:00 AM</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital 301 Hospital Drive Glen Burnie</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Anne Arundel</b>          |  | 4c. County of Death<br><b>Anne Arundel</b>                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-16-2634</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 6 1923</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>ANNE ARUNDEL</b>                                   |  | 10c. City, Town or Location<br><b>PASADENA</b>             |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1084 NOTLEY COURT</b>  |  | 10f. Zip Code<br><b>21122</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9TH GRADE</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>OFFICE MANAGER</b>  |  | 16b. Kind of Business/Industry<br><b>UNITED IRON &amp; METAL</b>  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>RICHARD COGSWELL</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EMMA HICKMAN</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DENISE MOYLAN (DAUGHTER)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1084 NOTLEY COURT - PASADENA, MD 21030</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CRESTLAWN CEMETERY</b>   |  | 20c. Date<br><b>7/24/96</b>   |  | 20d. Location - City or Town, State<br><b>BALTIMORE MD</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME, INC.<br/>4107 WILKENS AVENUE - BALTIMORE, MD 21229</b>   |  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>END STAGE CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>Due to (or as a consequence of):<br>b. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ATRIAL FIBRILLATION</b><br><b>ARTHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>  |  |   |  |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of injury (Month, Day, Year)   |  |  |
| 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br> <b>MD</b>  |  | 29c. License number<br><b>D43977</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 20th 1996</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHORON DRETHUR 301 HOSPITAL DRIVE, GLEN BURNIE MD. 21061</b>   |  |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  |   |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

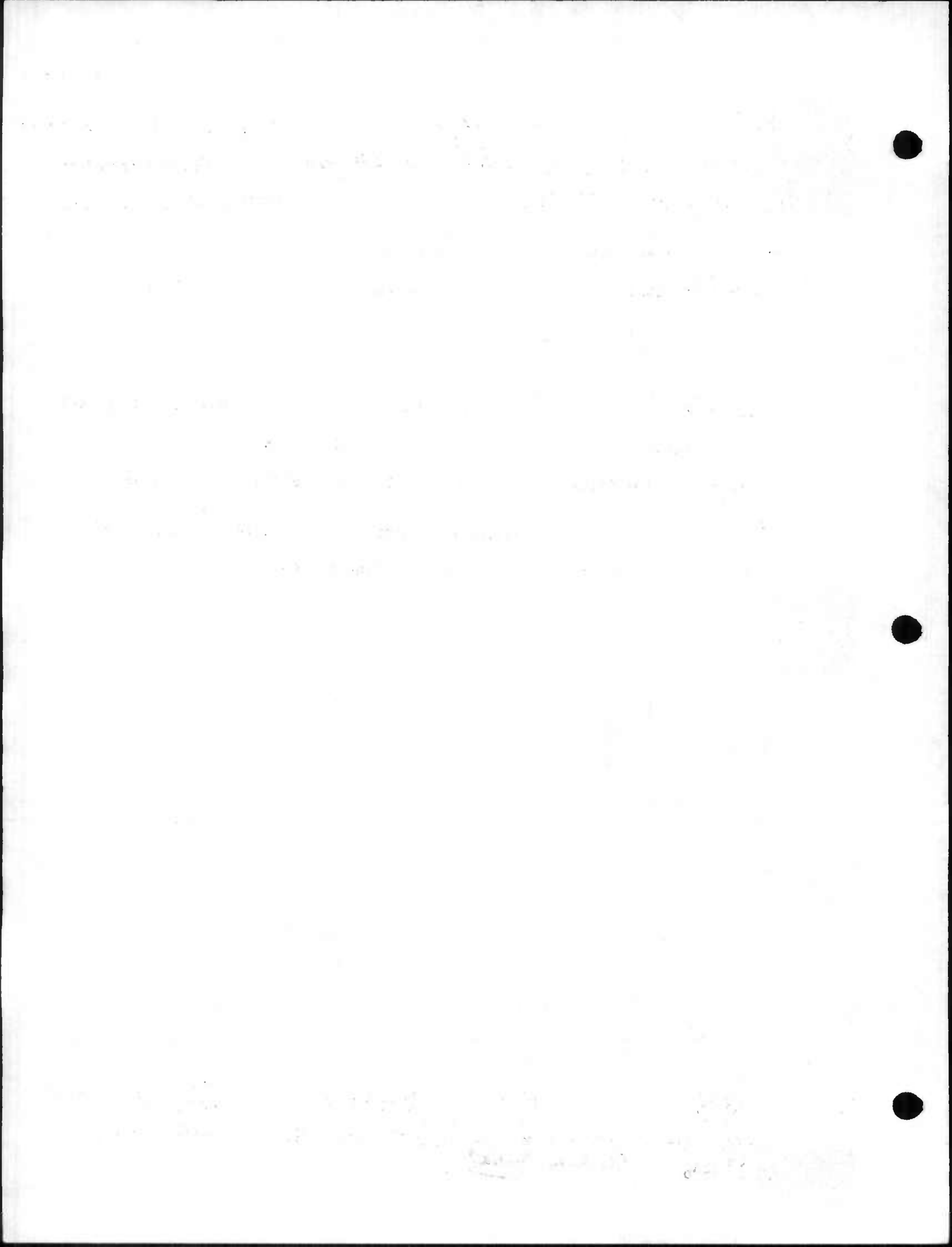
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21680

## Certificate of Death

Reg. No.

|  |   |  |   |                                |  |
|--|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Thomas E. Brown Jr.</i>  |  | 2. Date of Death<br>Month <i>7</i> Day <i>21</i> Year <i>96</i>   |                                | 3. Time of Death <i>10:56 AM</i>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Seton Hill manor</i>   |  | 4b. City, Town, or Location of Death<br><i>Balt. md</i>   |                                | 4c. County of Death <i>N/A</i>   |
| Funeral<br>Director  | 5. Social Security Number<br><i>214-567865</i>  | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>46</i> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 6. Date of Birth (Month, Day, Year)<br><i>5-3-50</i>  |  | 9. Birthplace (State or Foreign Country)<br><i>Balt. md</i>   |                                |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  | 10a. State<br><i>md</i>   |                                | 10b. County<br><i>City</i>   |
|  | 10c. City, Town or Location<br><i>Baltimore</i>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                |  |
|  | 10e. Street and Number<br><i>3831 Reisterstown Rd</i>   |  | 10f. Zip Code<br><i>21215</i>   |                                | 10g. Citizen of What Country?<br><i>USA</i>  |
|  | 11. Marital Status<br><i>Separated</i><br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:       |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th grade</i><br>College (1-4 or 5+) <i>2 yrs</i>    |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Chef</i>   |
|  | 16b. Kind of Business/Industry<br><i>Food</i>   |  | 17. Father's Name (First, Middle, Last)<br><i>Thomas E. Brown, Sr.</i>  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Sylvia Brown</i>   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Hilda Brown/Wife</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3841 Reisterstown Rd. Baltimore, Maryland 21215</i> |                                |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>METRO CREMATORY</i>  |                                | 20c. Location - City or Town, State<br><i>Baltimore, Maryland</i>  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><i>WILLIAM C. BROWN COMMUNITY F/H<br/>1206 W. NORTH AVENUE</i>  |                                |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.<br><br><i>Liver Failure</i><br><i>Alcoholic Liver Disease</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><i>Acquired Immunodeficiency disease</i> |  |   |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |   |                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |   |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |   |                                |  |
| 28a. Date of injury (Month, Day Year)<br><i>7/21/96</i>  |   |  |   |                                |  |
| 28b. Time of Injury<br><i>M</i>  |   |  |   |                                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                |  |
| 28d. Describe how injury occurred  |   |  |   |                                |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |                                |  |
| 29b. Signature and title of certifier<br><i>Carla S. Alexander MD</i>  |   |  |   |                                |  |
| 29c. License number<br><i>D27087</i>   |   |  |   |                                |  |
| 29d. Date signed (Month, Day, Year)<br><i>7/21/96</i>  |   |  |   |                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>CARLA SALEXANDER CHASE BREXTON HS. 1001 Cathedral St Balt md 21201</i>  |   |  |   |                                |  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 23 1996</i>  |   |  |   |                                |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |   |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21681

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Booker BRYANT</b>  |  |  |  | 2. Date of Death<br>Month <b>7</b> Day <b>17</b> Year <b>96</b>  |  | 3. Time of Death<br><b>7:46 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Joseph Richey Hospice</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-01-9873</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 5, 1912</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>ARKANSAS</b>   |  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>825 BROOKS LANE</b>   |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942 to 1945</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th grade</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LONGSHORE MAN</b>  |  | 16b. Kind of Business/Industry<br><b>SHIP YARD</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>HOLDER BRYANT</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>OSSIE BRYANT</b>   |  |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda Trice/Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5349 Carriage Court, Baltimore Maryland 21229</b>  |  |  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VETERANS</b>  |  | 20c. Location - City or Town, State<br><b>OWINGS MILLS, MARYLAND</b>   |  |   |  |
|   | 21. Signature of Funeral Service Director<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>WILLIAM C. BROWN COMMUNITY F/H<br/>1206 W. NORTH AVENUE</b>   |  |  |  |   |  |
|   | 23a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Respiratory arrest</b><br>Due to (or as a consequence of):<br>b. <b>Metastasis brain, liver + bone</b><br>Due to (or as a consequence of):<br>c. <b>Carcinoma, unknown primary</b><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>minutes</b><br><b>2 weeks</b><br><b>unknown</b> |  |  |  |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   |   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i> <b>Dr. B. Finn, M.D.</b> |  | 29c. License number<br><b>DO2175</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7-19-96</b>                            |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Robt B. Finn, M.D., 8824 Winards Road, Randallstown, MD 21153</b>  |   | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>                              |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





96 21682

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |  |  |   |  |  |
|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DR. MAX BAUM   |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 19 1996   |   | 3. TIME OF DEATH<br>8 A M                      |  |
| 4. SOCIAL SECURITY NUMBER<br>220-05-8874   | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br>83 YRS.  | 7. DATE OF BIRTH (Month, Day, Year)<br>MAY 28, 1913  | 8. BIRTHPLACE (State or Foreign Country)<br>MD  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>7 SLADE AVE; APT. 103  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE   |   | 9c. COUNTY OF DEATH<br>BALTIMORE               |  |
| RESIDENCE OF DECEDENT  |   |  |  |   |  |  |
| 10a. STATE<br>MD   | 10b. COUNTY<br>BALTIMORE  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |
| 10e. STREET AND NUMBER<br>7 SLADE AVE.; APT. 103   |   |  | 10f. ZIP CODE<br>21208   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII - NAVY | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5+<br>College (1-4 or 5+) 5+  |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>PHYSICIAN  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>MEDICINE  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>LOUIS BAUM  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ANNIE BAUM  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>DR. RICHARD BAUM (SON)   |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2205 CROSS COUNTRY BLVD; BALTIMORE, MD 21209  |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>SHAAREI TFILOH 7-21-96  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joel D. Levinson</i>   |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Sol Levinson & Bros., Inc.<br>8900 Reisterstown Road Pikesville, MD 21208  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CORONARY ATHEROSCLEROTIC HEART DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. HYPERTENSION<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |   |  |  |   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |   |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |   |  |  |   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY<br>M   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                | 28d. DESCRIBE HOW INJURY OCCURRED              |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael L. Fisher MD</i>   |   |  | 29c. LICENSE NUMBER<br>D15317  |   | 29d. DATE SIGNED (Month, Day, Year)<br>7/19/96 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MICHAEL L. FISHER, MD 22 S. GREENE ST, BALTIMORE, MD 21201  |   |  |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 23 1996   |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21683

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |  |   |  |
|---|--|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LAURA BERRY</b>   |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>15</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>3:20 Am</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>n/a</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-24-9658</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb 7, 1912</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |  |
|   | Usual Residence of Decedent  |   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>5010 Pembridge Avenue</b>   |   |   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade School</b><br>College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>                      |  | 16b. Kind of Business/Industry<br><b>Private Family</b>  |  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Albert Green</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nannie Fitzgerald</b>  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Bell</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5010 Pembridge Avenue Baltimore, MD 21215</b>  |  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veteran Cemetery/Garrison</b>                                     |  | Date<br><b>July 19</b>   |  | 20c. Location - City or Town, State<br><b>Owings Mills, Maryland</b>                           |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>H. E. Nutter</b>   |   |   |  | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</b>  |  |  |   |  |
|   | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Due to (or as a consequence of):<br><b>CEREBROVASCULAR ACCIDENT</b><br><br><b>HYPERTENSION</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>INSULIN DEPENDENT DIABETES MELLITUS</b><br><br>Approximate Interval Between Onset and Death |   |   |  |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |   |  |  |  |  |   |  |
| 23c. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |  |  |   |  |
| 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>LIVER CIRRHOSIS</b><br><b>OLD CEREBROVASCULAR ACCIDENT</b>   |  |   |   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Ellie G. Cohen MD</b>   |   | 29c. License number<br><b>AS 2402321-EC9008</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 15, 1996</b>                      |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ELLIE G COHEN MD SINAI HOSPITAL 2401 W. BELVEDERE AVE BALTIMORE MARYLAND 21215</b>   |  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  |   |   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,


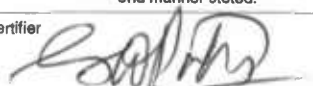
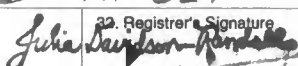


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21684

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |                                |  |  |
|--|---|--|---|--|---|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARY E. BROWN</b>  |  |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>18</b> Year <b>1996</b>  |                                | 3. Time of Death<br><b>4:30 P.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Liberty Medical Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                | 4c. County of Death<br><b>n/a</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-24-1521</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br><b>July 17, 1925</b>                   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |
|  | Usual Residence of Decedent   |  |   |  |   |                                |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |                                |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|  | 10e. Street and Number<br><b>2022 Ruxton Avenue</b>   |  |   |  | 10f. Zip Code<br><b>21216</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>          |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th Grade</b>   |  | College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |                                | 16b. Kind of Business/Industry<br><b>Family</b>                                  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Brown</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Juanita Hall</b>  |                                |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print) <b>SON</b><br><b>Gary Brown</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2022 Ruxton Avenue Baltimore, Maryland 21216</b>  |                                |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery</b>   |  | Date<br><b>July 23</b>  |                                | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</b>   |                                |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of): <b>with</b><br><b>b. COMPLETE HEART BLOCK.</b><br>Due to (or as a consequence of):<br><b>c. ARTERIOSCLEROTIC HEART DISEASE</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Approximate Interval Between Onset and Death<br><b>2 days</b><br><br><b>unknown.</b> |  |   |  |   |                                |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>- HYPERTENSION</b><br><b>- DIABETES MELLITUS</b>   |  |   |  |   |                                |  |  |
| State<br>Registrar   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |                                |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred   |                                |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                |  |  |
|  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 23300</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 18 1996</b>  |                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SUDHIR D. PATEL, 2800 Liberty RD, Baltimore MD, 21215</b> |   |  |   |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |   |  |   | 32. Registrar's Signature<br> |   |                                |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

COY

ASTORIA

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ENTER INVEST

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JUL 24 1939

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21685

|  |   |   |  |  |                                |  |  |  |  |
|--|---|---|--|--|--------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>BRANDON KEITH BENNETTS</b>           |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>15</b> Year <b>1996</b>   |                                | 3. Time of Death<br><b>2215PM</b>  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>BAY BRIDGE</b> |   |  | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>   |                                | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>231-37-4035</b>                                     |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>25</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>September 7, 1970</b> | 9. Birthplace (State or Foreign Country)<br><b>Mississippi</b>     |  |
|  | Usual Residence of Decedent   |   |  |  |                                |  |  |  |  |
| 10a. State<br><b>Virginia</b>  |   | 10b. County<br><b>Spotsylvania</b>  |  | 10c. City, Town or Location<br><b>Fredericksburg</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br><b>9316 Antler Court</b>   |   |   |  | 10f. Zip Code<br><b>22407</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Ceramic Tile Setter</b>   |                                | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Russell Bennetts</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Betty M. Brown</b>   |                                |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carrie J. Bennetts, Wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9316 Antler Court, Fredericksburg, Va. 22407</b>   |                                |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Stafford Memorial Park</b>   |  | Date<br><b>7/19/96</b>   |                                | 20c. Location - City or Town, State<br><b>Stafford, Virginia</b>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Kevin L. Boudin</b>  |   |   |  | 22. Name and Address of Facility<br><b>Mountcastle Funeral Home<br/>4143 Dale Blvd., Dale City, Virginia 22193</b>   |                                |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Multiple injuries and drowning</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |  |                                |  |  | Approximate Interval Between Onset and Death                       |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|  |   |   |  |  |                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
|  |   |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |  |  |                                |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>7-15-96</b>  |  | 28b. Time of Injury<br><b>2035 M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Jumped from Bay Bridge</b> |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Bay Bridge</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Bay Bridge</b>  |                                |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><b>Dennis J. Chute</b>   |  | 29c. License number<br><b>O.C.M.E.</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>JULY 16, 1996</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201</b>  |   |   |  |  |                                |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |                                |  |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21686  
Certificate of Death

Reg. No.

|   |   |   |   |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
|---|---|---|---|---|--|--|--|--|---|---|-------------------|---------|--------------|------|-------------|-------|----------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>HENRY F. BECKER   |   |   |   | 2. Date of Death<br>Month Day Year<br>JULY 16, 1996  |  | 3. Time of Death<br>9:05 P.M.  |  |   |   |                   |         |              |      |             |       |                            |
|   | 4a. Facility Name (If not institution, give street and number)<br>2810 HENLY ROAD   |   |   |   | 4b. City, Town, or Location of Death<br>BEL AIR  |  | 4c. County of Death<br>HARFORD   |  |   |   |                   |         |              |      |             |       |                            |
| Funeral<br>Director   | 5. Social Security Number<br>579-01-0973  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>82 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>APRIL 2, 1914   | 9. Birthplace (State or Foreign Country)<br>BALTIMORE CITY, MD |   |   |                   |         |              |      |             |       |                            |
|   | Usual Residence of Decedent   |   |   |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
| To Be Completed by Funeral Director   | 10a. State<br>MARYLAND  |   | 10b. County<br>HARFORD  |   | 10c. City, Town or Location<br>BEL AIR   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |   |                   |         |              |      |             |       |                            |
|   | 10e. Street and Number<br>2810 HENLY ROAD   |   |   |   | 10f. Zip Code<br>21015   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |   |   |                   |         |              |      |             |       |                            |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |  |   |   |                   |         |              |      |             |       |                            |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9<br>College (1-4 or 5+) N/A   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SHEET METAL WORKER                       |   | 16b. Kind of Business/Industry<br>CONSTRUCTION INDUSTRY  |  |  |  |   |   |                   |         |              |      |             |       |                            |
|   | 17. Father's Name (First, Middle, Last)<br>HENRY BECKER   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>TERESA BARBARA BUETTNER   |  |  |  |   |   |                   |         |              |      |             |       |                            |
| Physician<br>/Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>KATHERINE E. BECKER (WIFE)  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2810 HENLY ROAD BEL AIR, MARYLAND 21015   |  |  |  |   |   |                   |         |              |      |             |       |                            |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>PARKWOOD CEMETERY JULY 19, 1996   |   | Date<br>JULY 19, 1996  |  | 20c. Location - City or Town, State<br>BALTIMORE, MARYLAND   |  |   |   |                   |         |              |      |             |       |                            |
|   | 21. Signature of Funeral Service Licensee<br><i>Booth</i>   |   |   |   | 22. Name and Address of Facility<br>LASSAHN FUNERAL HOME, INC.<br>7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625  |  |  |  |   |   |                   |         |              |      |             |       |                            |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td rowspan="4">Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>a. Cardiac Arrest</td> <td>Minutes</td> </tr> <tr> <td>b. Pneumonia</td> <td>Days</td> </tr> <tr> <td>c. Diabetes</td> <td>Years</td> </tr> <tr> <td>d. Coronary Artery Disease</td> <td>year</td> </tr> </table> |   |   |   |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Cardiac Arrest | Minutes | b. Pneumonia | Days | c. Diabetes | Years | d. Coronary Artery Disease |
| Immediate Cause (Final disease or condition resulting in death)   | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. Cardiac Arrest   | Minutes   |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
|   |   | b. Pneumonia  | Days  |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
|   |   | c. Diabetes   | Years   |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
|   |   | d. Coronary Artery Disease  | year  |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Dementia  |   |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |   |                   |         |              |      |             |       |                            |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |   |                   |         |              |      |             |       |                            |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                              |   |   |                   |         |              |      |             |       |                            |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br>David H Madoff MD, PhD   |   |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
| 29c. License number<br>D31419, Maryland   |   | 29d. Date signed (Month, Day, Year)<br>7/17/96  |   |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David H Madoff MD PhD. 5601 Loch Raven Blvd. Baltimore, Md 21239  |   |   |   |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |
| 31. Date filed (Month, Day, Year)<br>7/1 JUL 23 1996  |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |   |  |  |  |  |   |   |                   |         |              |      |             |       |                            |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



## Certificate of Death

Reg. No.

21687

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

DEQUAN Anthony BAILEY

2. Date of Death

Month Day Year  
JULY 15, 1996

3. Time of Death

10:07 A

4a. Facility Name (If not institution, give street and number)

ST. agnes hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

5. Social Security Number n/a

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 5, 1996

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

114 Nunnery Lane Apt. D

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

n/a

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

n/a

16b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

Bryant Anthony Bailey

18. Mother's Name (First, Middle, Maiden Surname)

Lakeyya Veshawn Rideout

19a. Informant's Name/Relationship (Type, Print) mother

Lakeyya Rideout

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 Nunnery Lane Apt. Baltimore, MD 21228

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Western Star Cemetery

Date

July 19

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.  
2501 Gwynns Falls Parkway  
Baltimore, Maryland 2121623a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

SUDEN INFANT DEATH SYNDROME

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☒ Yes ☐ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

Hospital:

☐ Inpatient ☒ Outpatient

26. Place of Death (Check only one)

☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☒ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dennis J. Chuteau

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 16, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chuteau 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit


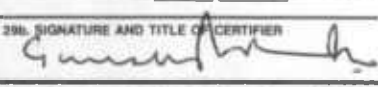
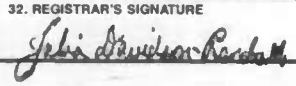
Medical Certification: To Be Completed by Physician/Medical Examiner



ITEMS: 16a,16b, PER WIFE FILM G-737 7/29/96 t.t

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert Stayton Christfield</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 21 1996</b>  |  | 3. TIME OF DEATH<br><b>5:26 P M</b>  |  |  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>221-20-8838</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 31, 1934</b>   |  |  |  |   |  |   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New Jersey</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fallston General Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Fallston</b>   |  |  |  |   |  |   |  |
| 9c. COUNTY OF DEATH<br><b>Harford</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Harford</b>  |  |  |  |   |  |   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Bel Air</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1004 Londonderry Drive</b>  |  |  |  |   |  |   |  |
| 10f. ZIP CODE<br><b>21015</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |  |  |   |  |   |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Real Estate Agent/INSURANCE</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>INSURANCE AGENCY/Realtor Office</b>   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John G. Christfield</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Audrey Stayton</b>   |  |  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Viola E. Christfield (wife)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1004 Londonderry Drive, Bel Air, MD 21015</b>  |  |  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory 7/23</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>  |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Schimunek Funeral Home of Bel Air, Inc.<br/>610 W. MacPhail Rd., Bel Air, MD 21014</b>  |  |  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>DME</b>   |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 21, 1996</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>G.S.Prabhu M.D. 1810 Belair Rd #102 Fallston MD. 21047 410-879-6564.</b>   |  |  |  |  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>JUL 23 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br>                        |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 687600 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



asp

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21689

## Certificate of Death

Reg. No.

|  |  |  |   |   |   |  |   |  |  |  |
|--|--|--|---|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>DERON ANTHONY COLEMAN  |  |   | 2. Date of Death<br>Month JULY Day 18 Year 1996   |   |  | 3. Time of Death<br>6:20 A  |  |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>4601 FRANKLINTOWN RD.  |  |   | 4b. City, Town, or Location of Death<br>BALTIMORE |   |  | 4c. County of Death<br>n/a  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>016-56-3150   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>24 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>DEC. 6, 1971   |  | 9. Birthplace (State or Foreign Country)<br>NEW YORK   |  |
|  | Usual Residence of Decedent  |  |   |   |   |  |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD   |  | 10b. County<br>n/a  |   | 10c. City, Town or Location<br>BALTIMORE  |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>3317 GARRISON BLVD.  |  |   |   | 10f. Zip Code<br>21216  |  | 10g. Citizen of What Country?<br>UNITED STATES  |  |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 <sup>th</sup> College (1-4 or 5+) -  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>CASHIER  |  |   | 16b. Kind of Business/Industry<br>RETAIL STORE                   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>ANTHONY CHRISTIAN   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>JOANNE K. COLEMAN  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>JOANNE COLEMAN   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>47 ROCKAWAY ST., unit #2, LYNN, mass., 01902   |  |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>OAKLAWN CEMETERY  |   | Date<br>7-23  |  | 20c. Location - City or Town, State<br>ROSLINALE, MASSACHUSETTS                                 |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Bernal D. Johnson   |  |   |   | 22. Name and Address of Facility<br>WM. C. MARCHE H.-1101 E. NORTH AVENUE   |  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Gun shot wounds of Head.<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |  |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |   |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  |   |  |  |  |
|  | 24e. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |   |  |   |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |   |  |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE |   |   |  |   |  |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br>7-18-96   |   | 28b. Time of injury<br>6-16 AM  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br>subject shot  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>street   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>4601 Franklinton Rd. |   |   |   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>[Signature]   |   | 29c. License number<br>O.C.M.E                    |   | 29d. Date signed (Month, Day, Year)<br>JULY 18, 1996 |   |  |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201   |  |  |   |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996   |  | 32. Registrar's Signature<br>[Signature]   |   |   |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P. O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21690  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen E. Cardwell

2. Date of Death

Month Day Year  
July 22, 1996

3. Time of Death

0330

4a. Facility Name (If not institution, give street and number)

Sina Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

Funeral  
Director

5. Social Security Number

215-10-6268

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 1, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2417 Cider Mill Rd.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Frank Cardwell

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Denny

19a. Informant's Name/Relationship (Type, Print)

William O. Long

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2417 Cider Mill Rd., Baltimore, Md. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Druid Ridge Cem. July 24, 1996

Date

20c. Location - City or Town, State

Pikesville, Md.

21. Signature of Funeral Service Licensee

H. J. Schmitt

22. Name and Address of Facility

Eckhardt Funeral Chapel

21117

11605 Reisterstown Rd., Owings Mills, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Intracerebral Hemorrhage

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

24 hours

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. Wilkinson MD

29c. License number

A52402321-JW9035

29d. Date signed (Month, Day, Year)

July 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeff Wilkinson MD, house staff

2401 W. Belvedere

Baltimore, MD 21215

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

J. Wilkinson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This form requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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96 21691

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN I. COLEMAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 21 1996</b>   |  | 3. TIME OF DEATH<br><b>9:11 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-26-6135</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 4, 1929</b>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mariner Health Care</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel</b>  |  | 9c. COUNTY OF DEATH<br><b>Prince George</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Carroll</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Millers</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4031 Schalk Rd. # 1</b>   |  |  |  | 10f. ZIP CODE<br><b>21102</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary 6 Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Homemaker</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ambrose Elijah Cool</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth Alice Gearhart</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Betty Keeney</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4031 Schalk Rd., # 1, Millers, Md. 21102</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Evergreen Mem. Gardens July 23, 1996 Finksburg, Md.</b>   |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>J. South Eckhardt</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Eckhardt Funeral Chapel<br/>3296 Charmil Dr., Manchester, Md. 21102</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <b>Septicemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
|  |  | c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
|  |  | d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>cerebrovascular accident</b><br><b>aortic aneurysm</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>2 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Marie A. Dobyns MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>029923</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/21/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>7243 Hammer Pkwy Greenbelt, Md.</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 23 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21692

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Edward Cofiell

2. Date of Death

Month Day Year  
July 17 1996

3. Time of Death

7:28 PM

4a. Facility Name (If not institution, give street and number)

43 Oakway Rd.

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

216-07-3919

6. Sex

1 ☐ M 2 ☐ F  
X

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 7, 1917

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

TIMONIUM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

43 Oakway Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII.

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11

n/a

16. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Conductor

16b. Kind of Business/Industry

Railway Industry

17. Father's Name (First, Middle, Last)

William T. Cofiell

18. Mother's Name (First, Middle, Maiden Surname)

Lottie B. Benson

19a. Informant's Name/Relationship (Type, Print)

Robert N. Cofiell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 Green Ridge Rd., Lutherville, MD 21093

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Grace U. Meth. Church

Date

20

20c. Location - City or Town, State

Cockeysville, MD

21. Signature of Funeral Service Licensee

Loretta M. Lemmon

22. Name and Address of Facility

Lemmon Funeral Home of Dulany Valley, Inc.  
10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 minutes

2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation, Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Susan Weiner, M.D.

29c. License number

D34941

29d. Date signed (Month, Day, Year)

7-22-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Weiner, M.D.

5601 Loch Raven Blvd., Balto., MD

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

W + V A



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21693

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |   |   |  |
|---|---|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>PUYEAR LOB B Jr.</b>                             |  |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>18</b> Year <b>1996</b> |   | 3. Time of Death<br><b>0400</b>                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>             |   | 4c. County of Death<br><b>CHESAPEAKE</b>              |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-301305</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.                     |   | 8. Date of Birth (Month, Day, Year)<br><b>9-16-32</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>                               |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>CHESAPEAKE</b>                                     |   | 10c. City, Town or Location<br><b>Baltimore</b>       |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>3-24-53</b><br>If Yes, Give Year or Dates: <b>3-16-55</b>                  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance</b>  |  | 16b. Kind of Business/Industry<br><b>Education Inst.</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Purveyar Cobb</b>   |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maybell Davis</b>   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Fannie Cobb</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3857 Forest Park Ave, Balto, MD 21216</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harrison Forest Veterans Cem.</b>  |   | 20c. Location - City or Town, State<br><b>7-24-96 Owings Mills, MD</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Irvin Carroll</b>  |  | 22. Name and Address of Facility<br><b>1712-14 W. North Ave, Balto, MD 21217</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br>b. <b>CORONARY ARTERY BYPASS SURGERY</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   |  |
| 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Dr. [Signature]</b>   |   |  |
| 29c. License number<br><b>046015</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>18 JUL 1996</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DOUGLAS S. WALLACE DEPT OF CT SYSTEM, UNIV OF MARYLAND, BALTIMORE, MD</b>   |  | 31. Data filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21694

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) MARGARET MARY COOK  
2. Date of Death Month JULY Day 19 Year 1996  
3. Time of Death 5:30 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number) CHESAPEAKE MANOR NURSING HOME  
4b. City, Town, or Location of Death ARNOLD  
4c. County of Death ANNE ARUNDEL

5. Social Security Number 138-20-1989  
6. Sex 1 ☐ M 2 ☒ F  
7. Age (In yrs. last birthday) 89 Yrs.  
8. Date of Birth (Month, Day, Year) 09-06-1906  
9. Birthplace (State or Foreign Country) NEW JERSEY

Usual Residence of Decedent

10a. State MARYLAND  
10b. County ANNE ARUNDEL  
10c. City, Town or Location GLEN BURNIE  
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 902 ROSE ANNE ROAD  
10f. Zip Code 21060  
10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) NONE  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PRACTICAL NURSE  
16b. Kind of Business/Industry HOSPITAL

17. Father's Name (First, Middle, Last) FRANCIS X. BRIGHTON  
18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH MCKENNA

19a. Informant's Name/Relationship (Type, Print) SHIRLEY TREAS (DAUGHTER)  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 ROSE ANNE ROAD, GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY, INC.  
20c. Location - City or Town, State BELTSVILLE, MD.  
20d. Date 7/22/96

21. Signature of Funeral Service Licensee  
22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MARYLAND 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure  
Due to (or as a consequence of): 1 week  
b. Previous Myocardial Infarction  
Due to (or as a consequence of): 2 years  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):  
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  
28. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day Year)  
28b. Time of Injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Dr. Whyman M.D. Attending Doctor  
29c. License number D 21684  
29d. Date signed (Month, Day, Year) 7-18-96

30. Name and address of person who completed cause of death (item 23a) (Type, Print) C.V. CYRIAC M.D. 1600 CRAIN AVE #106 GLEN BURNIE, MD 21061.

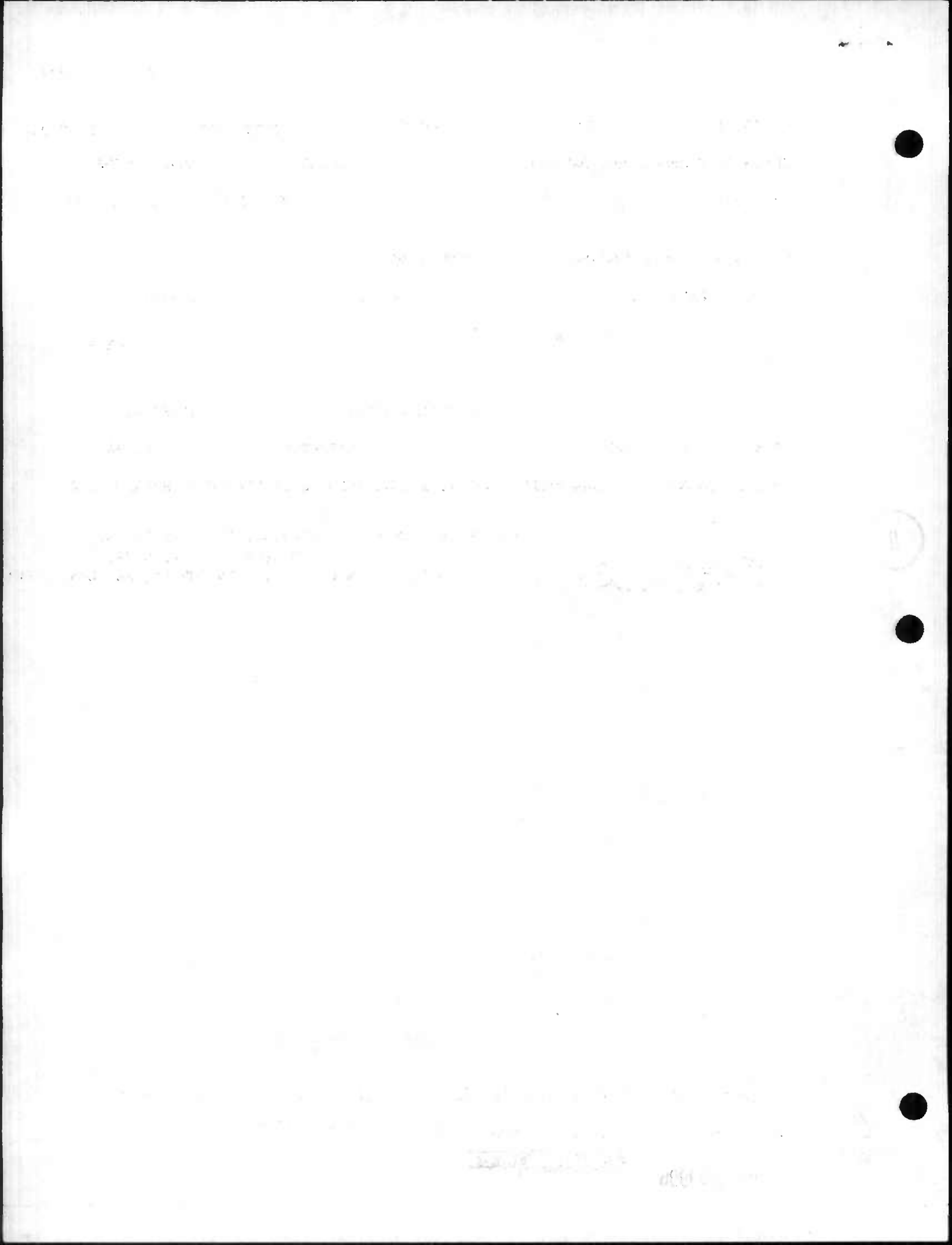
31. Date filed (Month, Day, Year) JUL 23 1996

State  
Registrar

Ballgame, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner



96 21695

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAUL C CONNER</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>18</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>900A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-05-8379</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>05-12-20</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Pleasant View Nursing Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Mt. Airy, Maryland</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Carroll</b>  |  |   |  | 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Frederick</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>5305 Allington Manor Ct.</b>  |  |
| 10f. ZIP CODE<br><b>21703</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Army WWII</b>   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>--</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrical Mechanic</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Atlas Vending</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Grover Carter Conner</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ella Marie Bogue</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Michael Conner</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5305 Allington Manor Ct. Frederick, Md 21703</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Carroll Cremation 7/19/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Hampstead, Md</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Harry W. Haight</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Haight Funeral Home<br/>P.O. Box 195 Sykesville, MD 21784</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBROVASCULAR ACCIDENT</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>CEREBROVASCULAR ACCIDENT</b><br>b.<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CORONARY ARTERY DISEASE</b> |  |   |  |  |  | Approximate interval Between Onset and Death<br><b>2 Hour</b>  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>7-18-96</b>   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>043091</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7-18-96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SARAH ZAHN 801 TOLL HOUSE AVE. FREDERICK</b>   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 23 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be kept within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21696

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|---|---|---|--|--|---|--|--|---|---|----|----------------------------------|--------------------------|------|----|----------------------------------|-----------------------------|--------|----|----------------------------------|-----------------|--------|----|----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Richard ALAN DAY  |   |  |  | 2. Date of Death<br>Month Day Year<br>Jul. 17, 1996   |  | 3. Time of Death<br>8:00 PM  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>1411 Glenwilde Road   |   |  |  | 4b. City, Town, or Location of Death<br>Catonsville   |  | 4c. County of Death<br>Baltimore   |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
| Funeral<br>Director   | 5. Social Security Number<br>507-20-6779  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>69 Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>JUNE 23, 1927   | 9. Birthplace (State or Foreign Country)<br>OMAHA, Nebraska |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |   | 10b. County<br>Baltimore   |  | 10c. City, Town or Location<br>Catonsville  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | 10e. Street and Number<br>1411 Glenwilde Road   |   |  |  | 10f. Zip Code<br>21228  |  | 10g. Citizen of What Country?<br>U. S. A.  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4 YRS  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>ACTUARY |   | 16b. Kind of Business/Industry<br>GOVERNMENT   |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | 17. Father's Name (First, Middle, Last)<br>CARL DAY   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ANNE ECKELSON  |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>BILLY DAY (COUSIN)  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. BOX 488 - LOUP CITY, NEBRASKA 68853   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br>WOODLAWN CEMETERY   |  | Data<br>7/23/96   |  | 20c. Location - City or Town, State<br>BALTIMORE MD  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | 21. Signature of Funeral Service licensee<br>Honey J. Thompson  |   |  |  | 22. Name and Address of Facility<br>HUBBARD FUNERAL HOME, INC.<br>4107 WILKENS AVENUE - BALTIMORE, MD 21229   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |  |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Due to (or as a consequence of):</td> <td>Ventricular Fibrillation</td> <td>1 hr</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> <td>Heart Myocardial Infarction</td> <td>10 yrs</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td>Atherosclerosis</td> <td>20 yrs</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> <td></td> </tr> </table> |   |  |  |   |  |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Due to (or as a consequence of): | Ventricular Fibrillation | 1 hr | b. | Due to (or as a consequence of): | Heart Myocardial Infarction | 10 yrs | c. | Due to (or as a consequence of): | Atherosclerosis | 20 yrs | d. | Due to (or as a consequence of): |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a.  | Due to (or as a consequence of):  | Ventricular Fibrillation   | 1 hr   |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | b.  | Due to (or as a consequence of):  | Heart Myocardial Infarction  | 10 yrs   |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | c.  | Due to (or as a consequence of):  | Atherosclerosis  | 20 yrs   |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   | d.  | Due to (or as a consequence of):  |  |  |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how Injury occurred  |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
|   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
| 29b. Signature and title of certifier<br>Raymond D. Bahr MD   |   |   |  | 29c. License number<br>D590  |   | 29d. Date signed (Month, Day, Year)<br>7/18/96   |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Raymond D. Bahr MD  |   |   |  |  |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996  |   |   |  |  |   |  |  |   |   |    |                                  |                          |      |    |                                  |                             |        |    |                                  |                 |        |    |                                  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21697

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Anthony Doemling

2. Date of Death

Month  
JulyDay  
21Year  
1996

3. Time of Death

10:05 am

4a. Facility Name (If not institution, give street and number)

Medbridge Rehabilitation Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-14-5894

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

09/19/1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4022 Ardley Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Steamfitter

16b. Kind of Business/Industry

U.S. Coast Guard

17. Father's Name (First, Middle, Last)

John F. Doemling

18. Mother's Name (First, Middle, Maiden Summa)

( Unknown )

19a. Informant's Name/Relationship (Type, Print)

Mr. Robert W. Pahr / Personal Rep.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8645 Richmond Avenue Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cemetery

Date

7/24/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Mark T. Zavoyna

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Esophageal Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GI bleed

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard S. Freeland MD

29c. License number

D28127

29d. Date signed (Month, Day, Year)

7-22-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Freeland, M.D.

5601 Loch Raven Blvd.

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

Julia Davidson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The second part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The third part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development.

2. The second part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The third part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The fourth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development.

3. The third part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The fourth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The fifth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development.

4. The fourth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The fifth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development. The sixth part of the report deals with the specific details of the country's development. It is a very detailed and thorough study of the country's development.



Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MATTHEW WELDON EWING</b>   |  |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>21</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>5:58 P.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>---</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-80-2888</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>March 6, 1958</b>                                 |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>NEBRASKA</b>   |  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>HARFORD</b>   |  | 10c. City, Town or Location<br><b>JARRETTSVILLE</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>4055 Trebor Ct.</b>   |  | 10f. Zip Code<br><b>21084</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1977-1981</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>---</b> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Operation Manager</b>  |  | 16b. Kind of Business/Industry<br><b>H.V.A.C. Distribution Industry</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Larry L. Ewing</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes L. Ewing</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Matthew W. Ewing</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4055 Trebor Ct., Jarrettsville, MD 21084</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>---</b> |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gardens</b>  |  | 20c. Location - City or Town, State<br><b>Timonium, MD</b>                                  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Lowell M. Lemmon</b>  |  | 22. Name and Address of Facility<br><b>Lemmon Funeral Home of Dulaney Valley, Inc.<br/>10 W. Padonia Rd. Timonium, MD 21093</b>  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>MULTIPLE MYOMIOS</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |  |  |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><b>dissection</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |   |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>---</b>   |  |  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>7 21 96</b>  |  | 28b. Time of Injury<br><b>1701P M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred<br><b>Passenger of car struck by</b>  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>McClure Blvd and Northwood, Baltimore</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>---</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |   |  |   |  |
|   | 29b. Signature and title of certifier<br><b>Walter D. Dineen</b>  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 22, 1996</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARYDAIS A. KORSE 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  | 32. Registrar's Signature<br><b>John A. Dineen</b>   |  |   |  |   |  |

CO + J R

1. The first part of the report is devoted to a general survey of the situation in the country.

2. The second part contains a detailed analysis of the economic situation.

3. The third part is devoted to a study of the social conditions.

4. The fourth part contains a summary of the results of the investigation.

5. The fifth part is devoted to a study of the political situation.

6. The sixth part contains a summary of the results of the investigation.




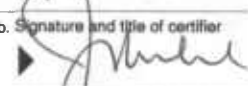
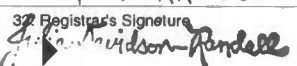
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State of Maryland / Department of Health and Mental Hygiene

96 21699

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |  |  |   |                             |  |   |          |    |  |    |
|---|--|--|---|---|--|--|--|--|---|-----------------------------|--|---|----------|----|--|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>GEORGE EVANS   |  |   |   | 2. Date of Death<br>Month Day Year<br>July 18 1996   |  | 3. Time of Death<br>6:25 PM                                      |  |   |                             |  |   |          |    |  |    |
|   | 4a. Facility Name (If not institution, give street and number)<br>Stella Maris Hospice   |  |   |   | 4b. City, Town, or Location of Death<br>Baltimore  |  | 4c. County of Death<br>N/A                                       |  |   |                             |  |   |          |    |  |    |
| Funeral<br>Director   | 5. Social Security Number<br>163-10-1573   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>85 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>March 13, 1911   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  |  |  |   |                             |  |   |          |    |  |    |
|   | Usual Residence of Decedent  |  |   |   |  |  |  |  |   |                             |  |   |          |    |  |    |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Howard  | 10c. City, Town or Location<br>Columbia   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |   |                             |  |   |          |    |  |    |
|   | 10e. Street and Number<br>5534 Coltsfoot Court   |  | 10f. Zip Code<br>21045  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |   |                             |  |   |          |    |  |    |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |   |                             |  |   |          |    |  |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Commercial Artist                              |   | 16b. Kind of Business/Industry<br>U.S. Postal Service  |  |  |  |   |                             |  |   |          |    |  |    |
|   | 17. Father's Name (First, Middle, Last)<br>George J. Evans, Sr.  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Maude Wilson  |  |  |  |   |                             |  |   |          |    |  |    |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Ruth Evans (Wife)  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5534 Coltsfoot Court Columbia, Maryland 21045   |  |  |  |   |                             |  |   |          |    |  |    |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc. July 20, 1996   |   | 20c. Location - City or Town, State<br>Catonsville, Maryland   |  |  |  |   |                             |  |   |          |    |  |    |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>Witzke Funeral Home of Columbia, Inc.<br>5555 Twin Knolls Road Columbia, Maryland 21045  |  |  |  |   |                             |  |   |          |    |  |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |  |  |  |   |                             |  |   |          |    |  |    |
|   | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. Congestive Heart Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/>1 week</td> </tr> <tr> <td>b. Atherosclerotic Cardiovascular Disease</td> <td>20 years</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |   |   |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. Congestive Heart Failure | Approximate Interval Between Onset and Death<br>1 week | b. Atherosclerotic Cardiovascular Disease | 20 years | c. |  | d. |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a. Congestive Heart Failure  | Approximate Interval Between Onset and Death<br>1 week                         |   |   |  |  |  |  |   |                             |  |   |          |    |  |    |
|   | b. Atherosclerotic Cardiovascular Disease  |  | 20 years  |   |  |  |  |  |   |                             |  |   |          |    |  |    |
|   | c.   |  |   |   |  |  |  |  |   |                             |  |   |          |    |  |    |
|   | d.   |  |   |   |  |  |  |  |   |                             |  |   |          |    |  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Peripheral Vascular Disease   |  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |   |                             |  |   |          |    |  |    |
|   |  |  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |                             |  |   |          |    |  |    |
|   |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |                             |  |   |          |    |  |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one) STELLA MARIS AT MERCY   |  |  |  |  |   |                             |  |   |          |    |  |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  |  |   |                             |  |   |          |    |  |    |
|   |  |  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |  |   |                             |  |   |          |    |  |    |
|   |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |                             |  |   |          |    |  |    |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   | 29b. Signature and title of certifier<br> MD |  | 29c. License number<br>D38675  |  |  |   |                             |  |   |          |    |  |    |
|   |  |  |   | 29d. Date signed (Month, Day, Year)<br>7/19/96  |  |  |  |  |   |                             |  |   |          |    |  |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JDC MESULAM 1147 S HANOVER ST BALTIMORE MD 21230  |  |  |   |   |  |  |  |  |   |                             |  |   |          |    |  |    |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996  |  |  |   | 32. Registrar's Signature<br>                |  |  |  |  |   |                             |  |   |          |    |  |    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Medical Examiner: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A death certificate has been signed by the attending physician and is completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21700

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Daniel Albert Eklund   |  |   |  | 2. Date of Death<br>Month Day Year<br>July 20, 1996  |  |  |  | 3. Time of Death<br>12:01 AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>5502 Plainfield Avenue   |  |   |  | 4b. City, Town, or Location of Death<br>Baltimore  |  |  |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-07-0988   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>85 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>12/07/1910                    |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD   |  | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>Baltimore   |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>5502 Plainfield Avenue   |  |   |  | 10f. Zip Code<br>21206   |  | 10g. Citizen of What Country?<br>U.S.A.                              |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                 |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Steel Worker  |  |  |  | 16b. Kind of Business/Industry<br>Steel Mill   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Daniel Webster Eklund   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Florence S. Cavey   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Mary M. Whitehead  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1303 Sheridan Place Unit M Belair, Maryland 21015   |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holy Redeemer Cemetery   |  | 20c. Location - City or Town, State<br>7/24/1996 Baltimore, Maryland |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Marvin J. Bippel Jr.</i>   |  |   |  | 22. Name and Address of Facility<br>The Dippel Funeral Home Inc.<br>7110 Belair Road Baltimore, Maryland 21206   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <i>myocardial infarction</i><br>Due to (or as a consequence of):<br><br>b. <i>Coronary artery disease</i><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |   |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |   |  |  |  |  |  |  |  |
| 28a. Date of Injury (Month, Day Year)<br>28b. Time of injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |  |  |  |  |
| 29b. Signature and Title of certifier<br><i>Jeffery A. Cool</i><br>29c. License number<br>D34650<br>29d. Date signed (Month, Day, Year)<br>7/22/96   |  |  |   |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Jeffery A. Cool Md 5601 Loch Raven Blvd. Baltimore, Maryland 21239   |  |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996<br>32. Registrar's Signature<br><i>Julia Burton-Randall</i>   |  |  |   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

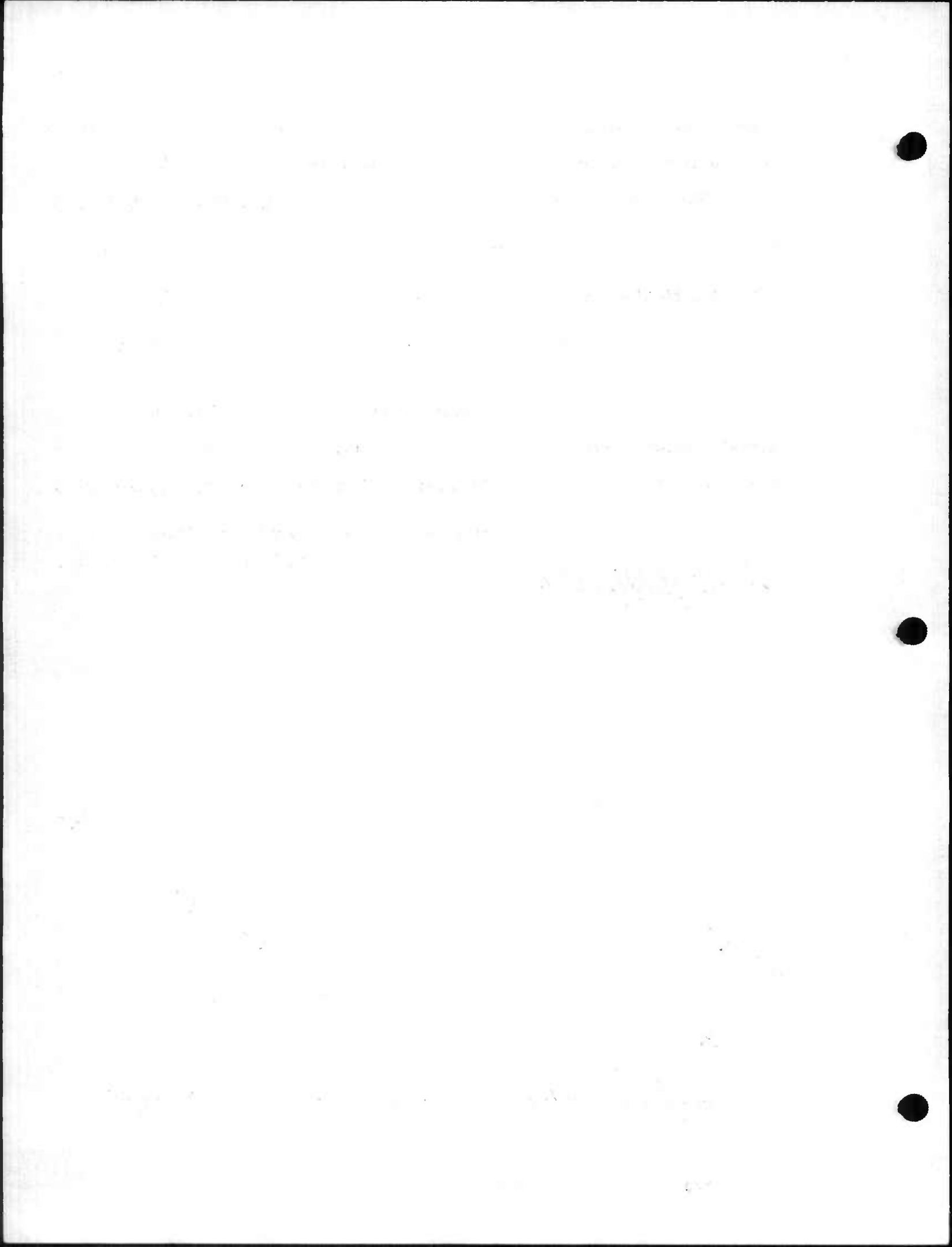
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 1. PER F.H. FILM G-737

State of Maryland / Department of Health and Mental Hygiene

96 21701

7/23/96 t.t

Film G738 item 4 per FH 8-1-96 rja

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT WILLIS FOLEY, SR.</b>  |  |   |  |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>20</b> Year <b>1996</b> |  | 3. Time of Death<br><b>7:33PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>  |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>           |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-10-2696</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>09/18/1918</b>             |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>GLEN BURNIE</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>6518 PAMPANO DRIVE</b>  |  |   |  | 10f. Zip Code<br><b>21061</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                       |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SHIPPING CLERK</b>   |  |  | 16b. Kind of Business/Industry<br><b>WESTINGHOUSE</b>          |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH FOLEY</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY (UNKNOWN)</b>   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT WILLIS FOLEY, JR. (SON)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>308 SKIPPER LANE, CHESTER, MD 21619</b>  |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>   |  | Date<br><b>7-23 1996</b>   |  | 20c. Location - City or Town, State<br><b>BROOKLYN PARK, MD</b>                                |  |
|  | 21. Signature of Funeral Service Licensee  |  |   |  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME<br/>1 SECOND AVENUE S.W., GLEN BURNIE, MD 21061</b>  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. GASTROINTESTINAL BLEEDING</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |   |  |  |  |  |  |  |  |
| 28a. Date of Injury (Month, Day, Year)   |  |  |   |  |  |  |  |  |  |  |
| 28b. Time of Injury<br><b>M</b>  |  |  |   |  |  |  |  |  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |  |  |  |  |
| 28d. Describe how injury occurred  |  |  |   |  |  |  |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  |  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>DR. J. K. GARUBA, MD</b>   |  |  |   |  |  |  |  |  |  |  |
| 29c. License number<br><b>D46029</b>   |  |  |   |  |  |  |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>JULY 20 1996</b>   |  |  |   |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ABDUL K. GARUBA, MD NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE</b>   |  |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |  |  |   |  |  |  |  |  |  |  |
| 32. Registrar's Signature<br><b>John Davidson Randall</b>  |  |  |   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delivered for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and a final conclusion about the significance of the study.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21702

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lee Jay Fletcher

2. Date of Death

Month Day Year  
July 22, 1996

3. Time of Death

0600

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

227-24-6151

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 14, 1924

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

106 Severn Drive

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Auto Mechanic

16b. Kind of Business/Industry

State Employee

17. Father's Name (First, Middle, Last)

Lonnie T. Fletcher

18. Mother's Name (First, Middle, Maiden Surname)

Emma Keyes

19a. Informant's Name/Relationship (Type, Print)

Ruth Fletcher

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 Severn Drive, Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veterans Cem.

Date

7/24/96

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Respiratory failure

Due to (or as a consequence of):

b.

Lung cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bladder cancer

Prostate cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D44465

29d. Date signed (Month, Day, Year)

7/20/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ann C. Mawey, 900 Beutgate Road, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registered Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 21703

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Berthe Faust   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 20, 1996   |  | 3. TIME OF DEATH<br>12:20 P. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-74-6215   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>94 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>9-19-1901  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>France   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Holly Hill Manor   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>N/A   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1216 Evesham Ave.  |  |  |  | 10f. ZIP CODE<br>21239  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Pierre Blistin  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Berthe Jouquez   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Loretta B. Malik (Daughter)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1216 Evesham Ave., Baltimore, Maryland 21239   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place)<br>Dunaway Valley Mem. Gards. 7-23-96  |  | 20c. LOCATION — City or Town, State<br>Timonium, amryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Wallace S. Brooke, Jr.  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ruck Towson Funeral Home, Inc.<br>1050 York Road, Towson, Md. 21204   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Carcinoma of the Breast   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Marc D. Leavey  |  |  |  | 29c. LICENSE NUMBER<br>D-17041  |  | 29d. DATE SIGNED (Month, Day, Year)<br>22 July 96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Marc Leavey, M. D. 7600 Osler Drive, Towson, Maryland 21204   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 23 1996   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Rodell  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



VOID

CERTIFICATE #

96-21704

SEE

CERTIFICATE #

96-23780

100.0000

0.000000

0.000000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21705

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MELVIN F. GITTINGS

2. Date of Death  
Month Day Year

July 22, 1996

3. Time of Death

1:25 AM

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON, MD

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

216-03-7209

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 30, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3999 Kahlston Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lead Crane Mechanic

16b. Kind of Business/Industry

Steel Company

17. Father's Name (First, Middle, Last)

Winfield Gittings

18. Mother's Name (First, Middle, Maiden Surname)

Mary Klima

19a. Informant's Name/Relationship (Type, Print)

Richard J. Gittings (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4148 Rupp Road, Millers, MD 21102

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Maus.

Data

7/24/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

## ACUTE MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

2 WEEKS

Immediate Cause (Final disease or condition resulting in death)

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

## RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30263

29d. Date signed (Month, Day, Year)

07-22-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, MD 7620 YORK ROAD TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9028.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the paper is devoted to a general discussion of the problem of the existence of solutions of the system of equations

$$\begin{aligned} \frac{dx}{dt} &= f(x, y, z) \\ \frac{dy}{dt} &= g(x, y, z) \\ \frac{dz}{dt} &= h(x, y, z) \end{aligned}$$

where  $f, g, h$  are continuous functions of  $x, y, z$  in a certain domain  $D$  of the three-dimensional space. It is assumed that the functions  $f, g, h$  satisfy the conditions of the theorem of existence and uniqueness of solutions.

The second part of the paper is devoted to the study of the properties of the solutions of the system of equations. It is shown that the solutions are unique and that they depend continuously on the initial conditions.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21706

## Certificate of Death

Reg. No.

|  |   |  |  |  |  |   |  |  |   |   |  |
|--|---|--|--|--|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>John Joseph Godlewski</b>                              |  |  |  |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1996</b>             |  | 3. Time of Death<br><b>7:10 AM</b>                          |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>VA MHCS FORT HOWARD DIVISION</b> |  |  |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                         |  | 4c. County of Death<br><b>Baltimore</b>                     |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-24-8807</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>July 24, 1929</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |  |
|  | 10a. State<br><b>Maryland</b>   |  |  |  |  |   | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>             |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br><b>2421 Arbuton Avenue</b>   |   |  |  |  |  | 10f. Zip Code<br><b>21230</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1955-57</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)   |   |  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>railroad worker</b>   |  |  | 16b. Kind of Business/Industry<br><b>Railroad</b>           |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Stanley Godlewski</b>  |   |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Viola Domino</b>  |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stewart Godlewski (son)</b>   |   |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7670 Hillsboro House Spring Rd, Hillsboro, MO 63050</b>   |  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery</b>   |  |  | Data<br><b>7/23</b>   |  | 20c. Location - City or Town, State<br><b>Brooklyn Park, MD</b>  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Nancy J. Thompson</i>  |   |  |  |  |  | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME, INC.<br/>Baltimore, MD 21229 4107 Wilkens Avenue</b>   |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |  |  |  |  |   |  |  |   |   | Approximate Interval Between Onset and Death<br><b>1 Month</b>                                 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |  |
|  |   |  |  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                           |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |  |  |  |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br><i>Medical Officer of the Day</i>   |   |  |  |  |  | 29c. License number<br><b>DA5148</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July, 20, 1996</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ricardo Osorno, MD 9600 North Point Road, Fort Howard, MD 21052</b>   |   |  |  |  |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |   |  |  |  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



ITEMS: 23 PART I, 27, 28a-f, PER  
ME0 FILM G-739 9/10/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21707

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen I. Gutkoska

2. Date of Death  
Month Day Year

7 19 96

3. Time of Death  
7:30 pm

4a. Facility Name (If not Institution, give street and number)

Union Mem Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

217-05-9765

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11-28-18

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

115 E

10f. Zip Code

21212

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

6th NA

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Teller

16b. Kind of Business/Industry

BANK

17. Father's Name (First, Middle, Last)

William Sims

18. Mother's Name (First, Middle, Maiden Surname)

Viola Cook

19a. Informant's Name/Relationship (Type, Print)

Cherree J. Spears - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

691 Skyline Way Westminister, MD. 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Woodlawn Cem

Date

7-24-96

20c. Location - City or Town, State

Woodlawn, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Albert P. Wylie Jr PA

638 N. Gilman Street

BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Urinary tract Infection

Due to (or as a consequence of):

c. Diabetes Mellitus

Due to (or as a consequence of):

d. FX OF TIBIA & FIBULA

Approximate  
Interval Between  
Onset and Death

2 days

2 weeks

20 yrs

JUNE 11, 1996

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart failure

Senile Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending  
Investigation

6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

JUNE 11, 1996

28b. Time of  
Injury

4 PM

28c. Injury at  
Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FELL FROM WHEEL CHAIR

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

LONG GREEN NURSING HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

115 MELROSE AVE.

BALTIMORE, MD. 21212

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alan B Cohen

29c. License number

D 3610

29d. Date signed (Month, Day, Year)

July 23, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Alan B. Cohen

200 E 33rd ST

Baltimore, MD 21218

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: The law requires that the death certificate be executed  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar

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Handwritten text at the bottom right of the page, possibly a date or a reference number.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 21708

Reg. No.

|  |   |   |  |  |  |   |   |  |
|--|---|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Salvan T. Graham</b>   |   |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>18th</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>7:31pm</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Liberty Medical Center</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |   | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>244-32-1917</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>May 14, 1927</b>              | 9. Birthplace (State or Foreign Country)<br><b>N. C.</b>   |
|  | Usual Residence of Decedent   |   |  |  |  |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Md.</b>  |   | 10b. County  |  | 10c. City, Town or Location<br><b>Baltimore City</b>   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>2200 Elsinore Avenue</b>   |   |  |  | 10f. Zip Code<br><b>21216</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>10/45-10/46</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>11th</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steel Worker</b>                                     |  | 16b. Kind of Business/Industry<br><b>Steel Industry</b>  |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Francis Reynolds</b>   |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Felecia Keys/Cousin</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2200 Elsinore Ave, Baltimore, Maryland 21216</b>   |   |   |  |
|  | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Veterans</b>  |  | Date<br><b>7/26/96</b>   |   | 20c. Location - City or Town, State<br><b>Garrison, Md.</b>             |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |  |  | 22. Name and Address of Facility<br><b>William C. Brown Community Funeral Home<br/>1206 W. North Avenue, Baltimore, Md. 21217</b>  |   |   |  |
|  | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Staph Aureus Sepsis</b><br>Due to (or as a consequence of):<br><b>b. Septic Shock</b><br>Due to (or as a consequence of):<br><b>c. Renal Failure</b><br>Due to (or as a consequence of):<br><b>d. Hypotension</b> |   |  |  |  |   |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           |   | 28d. Describe how Injury occurred  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i> <b>medical House officer</b>  |  | 29c. License number<br><b>D38993</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>7/18/96</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Kevin Elder MD 2600 Liberty Hgts Baltimore MD 21215</b>   |   |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 21709

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LONNIE LEE GRASTY  |  |  |  | 2. DATE OF DEATH<br>July 16, 1996 YEAR  |  | 3. TIME OF DEATH<br>7:00A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-20-2927   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>FEB 17, 1924  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>VA   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>VA Maryland Health Care System  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Perry Point   |  |
| 9c. COUNTY OF DEATH<br>Cecil   |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY<br>NA  |  |
| 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>1802 PRESSTMAN STREET  |  |
| 10f. ZIP CODE<br>21217   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>2-2-44 to 4-28-44  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th College (13-16) —  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Tailor  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Tailor Shop  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John H. Grasty  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Virginia Mason   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mildred Grasty   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3125 Mondomin Ave. Balto. Md. 21246  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Baltimore National Cem. 7-23-96  |  | 20c. LOCATION — City or Town, State<br>Balto. Md. 21215  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Anthony E. Ward Jr.   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>March 71st West 4300 Wabash Ave   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. * Arteriosclerotic Vascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br>20 yrs |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>A. S. Meron M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D2411  |  | 29d. DATE SIGNED (Month, Day, Year)<br>7/16/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Sirkumar Menon, M.D. Perry Point, MD 21902  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 23 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John H. Ward Jr.   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21710

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Willie M. Galbreath, Jr</i>   |  |  |  | 2. Date of Death<br>Month <i>7</i> Day <i>21</i> Year <i>96</i>   |  | 3. Time of Death<br><i>4:00pm</i>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>North Arundel Hospital</i>  |  |  |  | 4b. City, Town, or Location of Death<br><i>Anne Arundel</i>   |  | 4c. County of Death<br><i>Balto</i>                                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>241-22-2069</i>  |  | 6. Sex<br><i>1</i> M <i>2</i> F  |  | 7. Age (In yrs. last birthday)<br><i>70</i> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><i>Feb 26, 1926</i>              |  |
|  | 9. Birthplace (State or Foreign Country)<br><i>N.C.</i>  |  | 10a. State<br><i>Md</i>  |  | 10b. County<br><i>Anne Arundel</i>  |  | 10c. City, Town or Location<br><i>Glen Burnie</i>                       |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><i>1</i> Yes <i>2</i> X No  |  | 10e. Street and Number<br><i>6526 Pampano Drive</i>  |  | 10f. Zip Code<br><i>21061</i>   |  | 10g. Citizen of What Country?<br><i>U.S.A</i>                           |  |
|  | 11. Marital Status<br><i>1</i> Never Married <i>2</i> Married<br><i>3</i> X Widowed <i>4</i> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><i>1</i> Yes <i>2</i> X No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1</i> Yes <i>2</i> X No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i> |  |
| To Be Completed by Physician/Medical Examiner                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>unknown</i> College (1-4 or 5+) <i>NA</i>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Laborer</i>  |  | 16b. Kind of Business/Industry<br><i>Longshoreman</i>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Willie M. Galbreath</i>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mary Frances McLain</i>   |  |   |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Nicol Galbreath, Daughter</i>   |  |  |  | 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)<br><i>6526 Pampano Drive Glen Burnie, Md 21061</i>    |  |   |  |
|  | 20a. Method of Disposition<br><i>1</i> X Burial <i>2</i> Cremation <i>3</i> Removal from State<br><i>4</i> Donation <i>5</i> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Glen Haven Mem Park</i>   |  | 20c. Location - City or Town, State<br><i>Glen Burnie, Md</i>   |  | 20d. Date<br><i>7-20-96</i>   |  |
| To Be Completed by Physician/Medical Examiner                                | 21. Signature of Funeral Service Licensee<br><i>Portia Chron</i>   |  |  |  | 22. Name and Address of Facility<br><i>March F. H. West 4300 Wabash Avenue Balt, Md 21215</i>   |  |   |  |
|  | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. APPARENT ACUTE MYOCARDIAL INFARCTION 5 MINUTES</i><br>Due to (or as a consequence of):<br><i>b. CORONARY HEART DISEASE</i><br>Due to (or as a consequence of):<br><i>c.</i><br>Due to (or as a consequence of):<br><i>d.</i> |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Non-INSULIN dependent Diabetes</i><br><i>HYPERTENSION</i>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><i>1</i> Yes <i>2</i> X No <i>3</i> Probably <i>4</i> Unknown                             |  |   |  |
|  | 24a. Was an autopsy performed?<br><i>1</i> Yes <i>2</i> X No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><i>1</i> Yes <i>2</i> X No   |  |   |  |
| To Be Completed by Physician/Medical Examiner                                | 25. Was case referred to medical examiner?<br><i>1</i> X Yes <i>2</i> No   |  | 28. Place of Death (Check only one)<br>Hospital: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA Other: <i>4</i> Nursing Home <i>5</i> X Residence <i>6</i> Other (Specify) |  |   |  |   |  |
|  | 27. Manner of Death<br><i>1</i> X Natural <i>5</i> Pending investigation<br><i>2</i> Accident <i>6</i> Could not be determined<br><i>3</i> Suicide <i>4</i> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><i>M</i>   |  | 28c. Injury et Work?<br><i>1</i> Yes <i>2</i> No                        |  |
| To Be Completed by Physician/Medical Examiner                                | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|  | 29a. Certifier (Check only one)<br><i>1</i> X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><i>2</i> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>W. Mack</i> ATTENDING Phys.  |  | 29c. License number<br><i>D16200</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>7-22-96</i>                   |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Dr. N. M. MACHIRAN 720-C MAIDEN CHOICE LA. CATONSVILLE, 21228</i>   |  |  |  | 31. Date filed (Month, Day, Year)<br><i>JUL 23 1996</i>   |  |   |  |
|  | 32. Registrar's Signature<br><i>John Hudson-Rendell</i>  |  |  |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21711

Reg. No.

|  |   |  |   |  |  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|---|---|--|--|--|--|--|---|----------------------------------|--|--|--|--|--|--|-------------------|--|--|--|--|--|----------------|----------------------------------|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|----------------|----------------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Marie Lillian Green</b>  |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>9:20 am</b>   |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Maryland Manor conv. Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-74-0558</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 1, 1901</b>  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 10a. Street and Number<br><b>7575 E. Howard Road</b>  |  |   |  | 10f. Zip Code<br><b>21061</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Shiffette</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Williams</b>   |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Samuel J. Brown</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>123 Appian Way, Pasadena, MD 21122</b>   |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Morgan Chapel Cem.</b>   |  | Date<br><b>7/22/96</b>   |  | 20c. Location - City or Town, State<br><b>Woodbine, MD</b>   |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Daniel A. Arnold</i>  |  |   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, PA.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">Arteriosclerotic Cardiovascular Disease</td> <td>Approximate Interval Between Onset and Death<br/><b>10 years</b></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="6">Diabetes Mellitus</td> <td><b>6 years</b></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="6">Peripheral Vascular Disease</td> <td><b>8 years</b></td> </tr> <tr> <td colspan="6">Due to (or as a consequence of):</td> <td></td> </tr> </table> |  |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | Arteriosclerotic Cardiovascular Disease |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>10 years</b> | Due to (or as a consequence of): |  |  |  |  |  |  | Diabetes Mellitus |  |  |  |  |  | <b>6 years</b> | Due to (or as a consequence of): |  |  |  |  |  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Peripheral Vascular Disease |  |  |  |  |  | <b>8 years</b> | Due to (or as a consequence of): |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  | Arteriosclerotic Cardiovascular Disease   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>10 years</b>  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | Due to (or as a consequence of):  |  |   |  |  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | Diabetes Mellitus   |  |   |  |  |  | <b>6 years</b>   |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | Due to (or as a consequence of):  |  |   |  |  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Peripheral Vascular Disease   |  |   |  |  |  | <b>8 years</b>   |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | Due to (or as a consequence of):  |  |   |  |  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  |   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 29b. Signature and Title of certifier<br><i>Harjit Singh</i> (Attending Physician)  |  |   |  | 29c. License number<br><b>D14160</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>07/19/96</b>   |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225</b>   |  |   |  |  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |   |   |  |  |  |  |  |   |                                  |  |  |  |  |  |  |                   |  |  |  |  |  |                |                                  |  |  |  |  |  |  |  |                             |  |  |  |  |  |                |                                  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21712

|  |   |   |   |  |  |   |  |  |
|--|---|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Hazel Caroline GAJDOSIK   |   |   |  | 2. Date of Death<br>Month Day Year<br>July 17, 1996  |   | 3. Time of Death<br>11:50 Pm   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL  |   |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE COUNTY   |   | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-22-9969  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>70 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>JULY 27, 1925   |  |
|  | 10a. State<br>MARYLAND  |   | 10b. County<br>BALTIMORE  |  | 10c. City, Town or Location<br>BALTIMORE COUNTY  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br>7402 BROOKWOOD AVENUE   |   |   |  | 10f. Zip Code<br>21236   |   | 10g. Citizen of What Country?<br>U.S.A.  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) N/A  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER   |   | 16b. Kind of Business/Industry<br>HOUSEKEEPING-OWN HOME  |  |
|  | 17. Father's Name (First, Middle, Last)<br>CHARLES H. IHLE  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>HENRIETTA M. SCHAFER  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>TERRY P. GOJDOSIK (SON)   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6715 HAREWOOD PARK DRIVE BALTIMORE, MARYLAND 21220  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>METRO CREMATORY, INC.   |  | Date<br>JULY 18, 1996  |   | 20c. Location - City or Town, State<br>BALTIMORE, MARYLAND   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>LASSAHN FUNERAL HOME, INC.<br>7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Pancreatic Cancer</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  |
|  | Approximate Interval Between Onset and Death<br>1 year  |   |   |  |  |   |  |  |
|  | Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Lower gastrointestinal bleed, Anemia, Myocardial infarction, Coronary artery disease</u> |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |  |  |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|  |   |   |   |  |  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|  |   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |   |  |  |
|  |   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
|  | 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |   |  |  |
| State Registrar  | 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br>R D 2111  |   | 29d. Date signed (Month, Day, Year)<br>July 17, 1996   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Herman Junker 9000 Franklin Square Dr. Baltimore, Maryland 21237  |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996                     |   | 32. Registrar's Signature<br>  |   |  |  |   |  |  |

1. The first part of the paper is devoted to a general discussion of the problem of the existence of solutions of the system of equations (1) and (2) under the conditions (3) and (4). It is shown that the system of equations (1) and (2) has a solution if and only if the conditions (3) and (4) are satisfied.

2. In the second part of the paper, the existence of solutions of the system of equations (1) and (2) is proved for the case when the functions  $f(x)$  and  $g(x)$  are continuous and the functions  $h(x)$  and  $k(x)$  are piecewise continuous.

3. In the third part of the paper, the existence of solutions of the system of equations (1) and (2) is proved for the case when the functions  $f(x)$  and  $g(x)$  are continuous and the functions  $h(x)$  and  $k(x)$  are piecewise continuous. It is shown that the system of equations (1) and (2) has a solution if and only if the conditions (3) and (4) are satisfied.

4. In the fourth part of the paper, the existence of solutions of the system of equations (1) and (2) is proved for the case when the functions  $f(x)$  and  $g(x)$  are continuous and the functions  $h(x)$  and  $k(x)$  are piecewise continuous. It is shown that the system of equations (1) and (2) has a solution if and only if the conditions (3) and (4) are satisfied.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21713

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELEANOR

GEHRING

2. Date of Death

Month Day Year  
JULY 20 1996

3. Time of Death

8:15 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CROFTON CONVALESCENT CENTER

4b. City, Town, or Location of Death

CROFTON

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

218-16-1265

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10/4/1906

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

MILLERSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

LOT 44 ROL PARK TRL. VLG.

10f. Zip Code

21108

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (1-4 or 5+)

UNKNOWN

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

PETER

GILBERT

18. Mother's Name (First, Middle, Maiden Surname)

ELEANOR

ROGERS

19a. Informant's Name/Relationship (Type, Print)

JAMES F. GEHRING (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

LOT 44 ROL PARK TRL. VLG., MILLERSVILLE, MD 21108

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

7/23/96

20c. Location - City or Town, State

GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME

1 SECOND AVE. S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. End stage Alzheimer's disease

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. Laurie MD

29c. License number

D40519

29d. Date signed (Month, Day, Year)

7-22-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRZA M. NUSAIRI MD

7845 OAKWOOD Rd. 21061

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

Julia Harrison-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

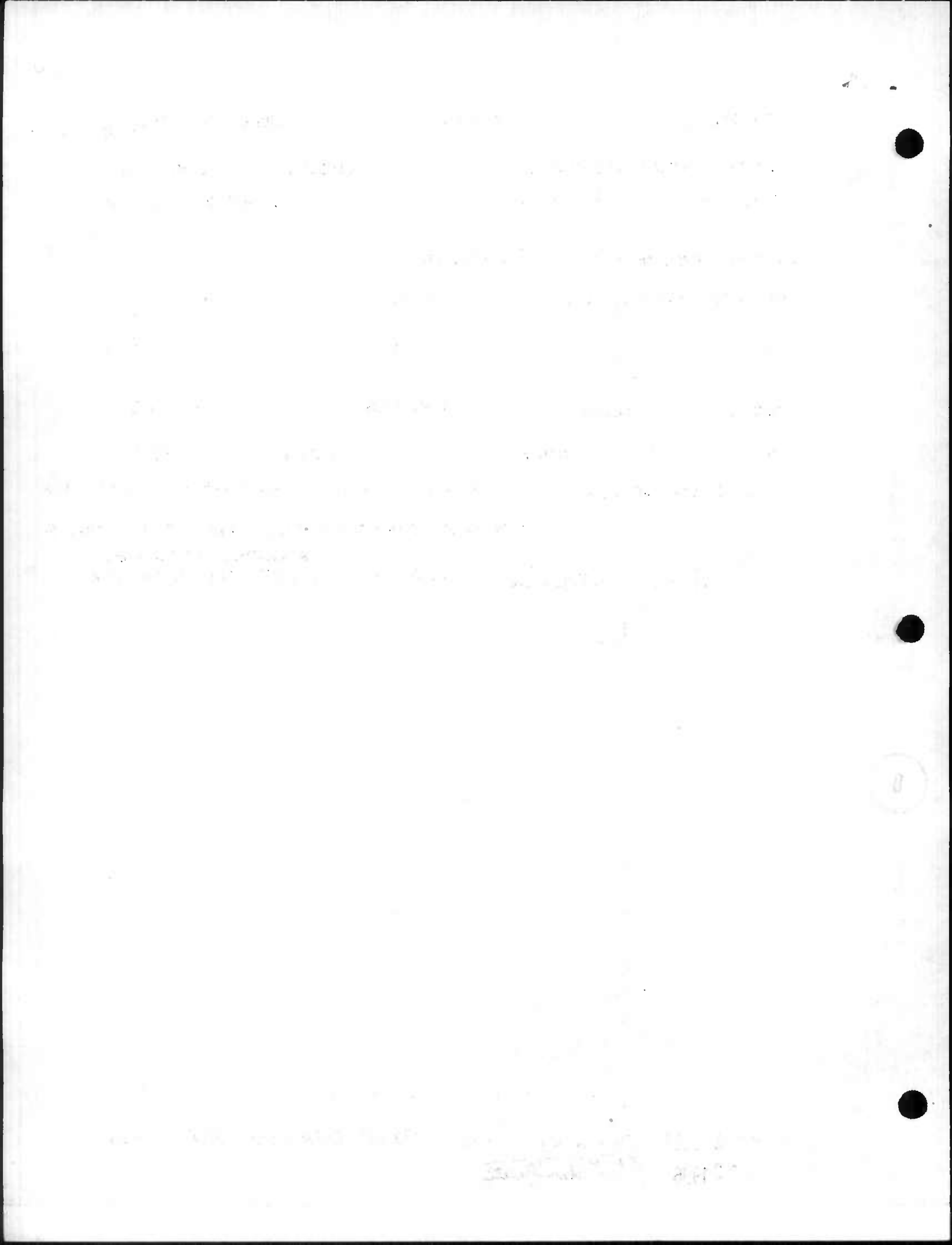
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

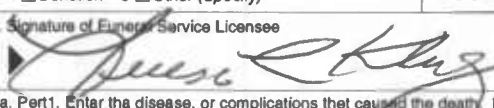
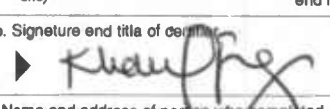





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 21714**  
**Certificate of Death**

Reg. No.

|  |   |   |   |  |  |   |  |   |  |
|--|---|---|---|--|--|---|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM THOMAS HALE</b>                    |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>21</b> Year <b>1996</b> |   | 3. Time of Death<br><b>6:30 PM</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>17010 Yeoho Road</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>Parkton</b>               |   | 4c. County of Death<br><b>Baltimore</b>  |   |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>212-09-8639</b>   |   | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                            | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 25 1910</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | Usual Residence of Decedent   |   |   |  |  |   |  |   |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Parkton</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>17010 Yeoho Road</b>  |   |   |   | 10f. Zip Code<br><b>21120</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer</b>   |  |   | 16b. Kind of Business/Industry<br><b>Koppers Co.</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Clarence Hale</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Blanche Alice Canapp</b>   |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gladys M. Naylor (daughter)</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17010 Yeoho Rd Parkton MD 21120</b>  |  |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b> |  | Data<br><b>7/24</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                                    |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |   | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME, INC.</b><br><b>4107 Wilkens Avenue, Baltimore, MD 21229</b>   |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>CA Colon with</b><br>Due to (or as a consequence of):<br><b>metastasis to liver</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>1 year</b><br><b>1 year</b> |   |   |   |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |  |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |   |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>D38415</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/22/96</b>                                       |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Khalil A. Freiji 295 Stoner Avenue, Suite 307, Westminster, MD 21157</b>  |   |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |   |   |   | 32. Registrar's Signature<br>   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. The first part of the document is a list of names and addresses. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

2. The second part of the document is a list of names and addresses, similar to the first part. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

3. The third part of the document is a list of names and addresses, similar to the first two parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

4. The fourth part of the document is a list of names and addresses, similar to the first three parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

5. The fifth part of the document is a list of names and addresses, similar to the first four parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

6. The sixth part of the document is a list of names and addresses, similar to the first five parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

7. The seventh part of the document is a list of names and addresses, similar to the first six parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

8. The eighth part of the document is a list of names and addresses, similar to the first seven parts. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 21715

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEFFERY LEE HARPER

2. Date of Death

Month Day Year  
JULY 20 1996

3. Time of Death

1:15A.M.

4a. Facility Name (If not institution, give street and number)

2903 HILLEN ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

233-19-9469

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

15 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
OCT. 26, 1980

9. Birthplace (State or Foreign Country)

WELCH, W. VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2136 E. FEDERAL STREET

10f. Zip Code

21213

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10 th

College (1-4 or 5+)  
-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STUDENT

16b. Kind of Business/Industry

HIGH SCHOOL

17. Father's Name (First, Middle, Last)

PAUL NEWCOMB

18. Mother's Name (First, Middle, Maiden Surname)

SABRINA HARPER

19a. Informant's Name/Relationship (Type, Print)

REGINA HARPER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2136 E. FEDERAL S T., BALTIMORE, M D 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING MEMORIAL PARK

Date

7-24

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

Bernard D. Johnson

22. Name and Address of Facility

WM. C. MARCH FH.-1101 E. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Gunshot wound of head

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

7 20 96

28b. Time of Injury

0104PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Gunshot wound

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

residence

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2903 Hillen Road Baltimore MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marjorie D. Kowal

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 20, 1996

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Maryland D. Kowal 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21716  
Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |  |   |
|---|---|--|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ADA Hess</b>   |  |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>7 AM</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>FRANKLIN Woods</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Rossville</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>232-38-6063</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.     | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>March 6, 1913</b>  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |
|   | Usual Residence of Decedent   |  |  |  | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Baltimore</b>  |   |
| To Be Completed by Funeral Director   | 10c. City, Town or Location<br><b>Middle River</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>6810 Cornell Road</b>   |   |
|   | 10f. Zip Code<br><b>21220</b>   |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |   |
|   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Westinghouse</b>  |  | 16b. Kind of Business/Industry<br><b>Westinghouse Plant</b>  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Mabe Dye</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Nanny Ashbrook</b>  |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda Bell</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6813 University Drive Baltimore MD. 21220</b>   |  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Cemetery 7/23/96</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore Md.</b>  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>R. Terry Connelly</b>   |  |  |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home Of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>   |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><b>b. Diabetes Mellitus</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Due to (or as a consequence of): |  |  |  | Approximate Interval Between Onset and Death  |  |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|   |   |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   |
|   |   |  |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |   |
|   |   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br><b>Philip Panzarella, MD.</b>  |  |  |   |
|   |   |  |  | 29c. License number<br><b>D 36643</b>                |   | 29d. Date signed (Month, Day, Year)<br><b>July 20, 1996</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PHILIP PANZARELLA, MD. FRANKLIN SQUARE HOSPITAL CENTER</b> |   |  |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |   |  |  | 32. Registrar's Signature<br><b>James W. Riddell</b> |   |  |  |   |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 69760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21717

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Russell Nathaniel Hall, Jr.

2. Date of Death

Month Day Year

July 19, 1996

3. Time of Death

2 P.M.

4a. Facility Name (If not institution, give street and number)

10280 Day Star Court

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard County

5. Social Security Number

218-76-1482

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 9, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

10280 Day Star Ct.

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Landscaper/Janitor

16b. Kind of Business/Industry

Social Security Adm.

17. Father's Name (First, Middle, Last)

Russell Nathaniel Hall, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Vertel Florinda Sjogren

19a. Informant's Name/Relationship (Type, Print)

Vertel F. Hall

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10280 Day Star Ct. Columbia, Md. 21044

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bushy Park Cemetery

Date

7/23/96

20c. Location - City or Town, State

Cooksville, Md.

21. Signature of Funeral Service Licensee

Harry W. Haight

22. Name and Address of Facility

Haight Funeral Home

P.O. Box 195 Sykesville, Md. 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Renal hemorrhage

Approximate  
Interval Between  
Onset and Death

2 wks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
Metastatic Colon Cancer

2 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pleural effusion (Right Side)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

George H. Sack, Jr.

29c. License number

D13190

29d. Date signed (Month, Day, Year)

July 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George H. Sack, Jr. Johns Hopkins Outpatient Ctr. Rm 7150.

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

J. Wilson

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death. This certificate has been signed by the attending physician and  
To the Funeral Director: This certificate has been signed by the attending physician and  
completely filled in by this funeral director, page 2 should be detached for use as the burial-transit  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

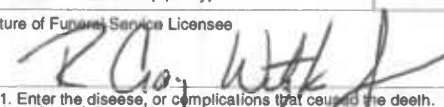
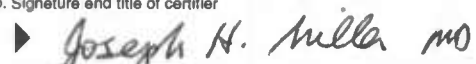
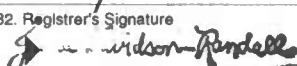




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 21718**  
**Certificate of Death**

Reg. No.

|   |  |   |  |   |  |   |  |  |
|---|--|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Daniel George Horsey</b>                    |   |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1996</b> |   | 3. Time of Death<br><b>5:00 AM</b>                               |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1908 Calais Court</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>             |   | 4c. County of Death<br><b>Baltimore</b>                          |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-30-4528</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.                     |   | 8. Date of Birth (Month, Day, Year)<br><b>September 24, 1934</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>                                      |   | 10c. City, Town or Location<br><b>Baltimore</b>                  |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1908 Calais Court</b>  |  | 10f. Zip Code<br><b>21244</b>   |  |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Years: _____ |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: _____ |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) _____   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bookbinder</b>                          |  | 16b. Kind of Business/Industry<br><b>Government Printing Office</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Dewey Schafter Horsey, Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eunice Rebecca Bell</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia P. Horsey</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1908 Calais Court Baltimore, Maryland 21244</b>     |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | Date<br><b>July 23, 1996</b>  |  | 20c. Location - City or Town, State<br><b>Catonsville, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Witzke Funeral Home of Catonsville, Inc.<br/>1630 Edmondson Avenue Catonsville, Maryland 21228</b>   |  |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Emphysema</b><br>Due to (or as a consequence of): _____<br><br>b. _____ Due to (or as a consequence of): _____<br><br>c. _____ Due to (or as a consequence of): _____<br><br>d. _____                 |  |   |  |   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____  |  |   |  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>A 06982</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 20, 1996</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOSEPH H. MILLER, MD 900 CATON AVE BALTIMORE 21229 MD</b>  |  |   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  | 32. Registrar's Signature<br>  |  |   |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

100

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a summary of the main findings and a discussion of the implications of the study. It includes a list of references and a bibliography.

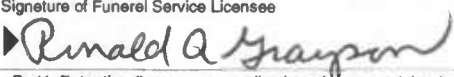
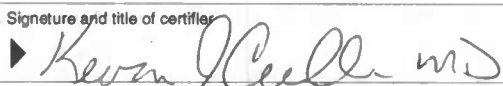
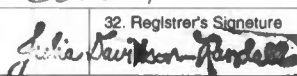
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21719

Reg. No.

|  |   |   |  |  |   |  |   |  |  |
|--|---|---|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>John Robert Jackson</b>  |   |  |  | 2. Date of Death<br>Month <b>7</b> Day <b>19</b> Year <b>96</b> |  | 3. Time of Death<br><b>10:18 pm</b>                   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Washington Adventist Hospital 7600 Carol Ave., Takoma Park, Md Mont.</b> |   |  |  | 4b. City, Town, or Location of Death                            |  | 4c. County of Death                                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>361-28-6230</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.                |  | 8. Date of Birth (Month, Day, Year)<br><b>1-10-37</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>KY</b>   |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Montgomery</b>                                |  | 10c. City, Town or Location<br><b>Silver Spring</b>   |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>8601 Manchester Rd., Apt. 400</b>   |   | 10f. Zip Code<br><b>20901</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ADP System Analyst</b>  |  | 16b. Kind of Business/Industry<br><b>District of Columbia Public Works</b>   |   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John R. Jackson</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ESSIE WARFIELD</b>   |   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JOHN R. JACKSON 3RD SON</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6616 FARGO ST SPRINGFIELD VA. 22150</b>  |   |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>NORTHERN VA CREMATORY</b>  |  | 20c. Location - City or Town, State<br><b>7-2596 ARLINGTON VA.</b>   |   |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Tri-State Funeral Services</b><br><b>6234 3rd Street, N.W. Washington, D.C.</b>   |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Hypercalcemia</b><br>Due to (or as a consequence of):<br>b. <b>Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>1 week</b><br><b>18 months</b> |   |   |  |  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br>  |  |  |   |  |   |  |  |
|  |   | 29c. License number<br><b>18956</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/20/96</b>  |   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Kevin B. Cullen, MD</b>   |   | <b>Georgetown University</b><br><b>3800 Reservoir Rd NW Washington DC 20057</b>   |  |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |   | 32. Registrar's Signature<br>  |  |  |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, Room Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21720

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |   |  |  |
|---|--|--|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLIE JORDAN</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 21, 1996</b>  |  | 3. Time of Death<br><b>5PM</b>  |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>1733 E. BALTIMORE STREET</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>   |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>239-48-4018</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 1, 1931</b>                                  |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>  |  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1733 E. BALTIMORE ST.</b>  |  | 10f. Zip Code<br><b>21231</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5TH</b> College (1-4 or 5+) <b>N/A</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>JANITOR</b>   |  | 16b. Kind of Business/Industry<br><b>FOUNTAIN BAPTIST CH.</b>   |  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>WILLIE JORDAN</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANN LIZZA KNIGHT</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ETHEL MAE JORDAN- WIFE</b>   |  |   |  |  |
| Physician<br>/Medical<br>Examiner             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1733 E. BALTIMORE ST. BALTO, MD. 21231</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>JULY 27, 1996 BALTIMORE, MARYLAND</b>             |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Calvin B. Scruggs Jr.</i>  |  | 22. Name and Address of Facility<br><b>CALVIN B. SCRUGGS FUNERAL HOME<br/>1412 E. PRESTON ST. BALTO, MD. 21213</b>  |  |   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Cancer Prostate with Met End Stage</i> <b>&gt;4y</b><br>Due to (or as a consequence of):<br>b. <i>Chronic Renal Failure</i> <b>2y</b><br>Due to (or as a consequence of):<br>c. <i>D. Metastasis</i> <b>2y</b><br>Due to (or as a consequence of):<br>d. <i>Multiple Myeloma</i> <b>4y</b> |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |
|   | 29c. License number<br><b>D14221</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7. 22 96</b>  |  |   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>T. D. Anderson, 223 E. Blue BALTO MD 21221</b>  |  |   |  |   |  |   | 31. Data filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |  |
|   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |  |   |  |   | 33. Registrar's Name<br><b>John A. Wilson-Randall</b>  |  |



|  |   |   |   |   |   |  |   |  |  |  |  |  |   |  |  |  |
|--|---|---|---|---|---|--|---|--|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Nama (First, Middla, Last)<br>John Jackson  |   |   | 2. Data of Death<br>Month Day Year<br>July 16, 1996 |   |  | 3. Time of Deeth<br>6:10 P.M.   |  |  |  |  |  |   |  |  |  |
|  | 4e. Facility Nama (If not institution, give street end number)<br>Crawford Retreat  |   |   | 4b. City, Town, or Location of Death<br>Baltimore   |   |  | 4c. County of Death<br>Balto City   |  |  |  |  |  |   |  |  |  |
| Funeral<br>Director  | 5. Social Sacurity Number<br>231 36 1937  |   | 6. Sax<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. iast birthday)<br>66 Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Data of Birth<br>(Month, Day, Year)<br>August 4, 1929 |  | 9. Birthplace (Stete or Foreign<br>Country) |  |  |  |
|  | Usual Residence of Dacedant   |   |   |   |   |  |   |  |  |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>Md.   |   | 10b. County<br>Carroll  |   | 10c. City, Town or Location<br>Sykesville   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |   |  |  |  |
|  | 10e. Street and Number<br>Main Street   |   |   |   | 10f. Zip Code<br>21784  |  |   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |   |  |  |  |
|  | 11. Mentel Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Evar In U.S.<br>Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates.<br>Korean   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Maxican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian,<br>Black, Whita, etc.<br>Specify: BLACK                                |  |  |  |   |  |  |  |
|  | 15. Decedant's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11<br>Collega (1-4or 5+) -  |   |   |   | 16a. Decedant's Usual Occupation<br>(Give kind of work done during most of working<br>lifa. DO NOT use retired)<br>Unknown  |  |   |  | 16b. Kind of Business/Industry<br>Unknown  |  |  |  |   |  |  |  |
|  | 17. Fether's Nama (First, Middla, Last)<br>Unknown  |   |   |   | 18. Mothar's Nama (First, Middle, Maiden Sumama)<br>Unknown   |  |   |  |  |  |  |  |   |  |  |  |
|  | 19a. Informant's Nama/Relationship (Type, Print)<br>Gail Jones  |   |   |   | 19b. Mallng Address (Street and Number or Rural Routs Number, City or Town, Stata, Zip Code)<br>7 Schoolhouse Road Westminster, Md.   |  |   |  |  |  |  |  |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   |   | 20b. Place of Disposition (Nama of<br>cemetary, crematory or other place)<br>Springfield Cemetery   |  |   |  | Data<br>7/18/96  |  | 20c. Location - City or Town, Stata<br>Sykesville, Md    |  |   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Harry W. Haight  |   |   |   | 22. Nama and Address of Facility<br>Haight Funeral Home<br>P.O.Box 195 Sykesville, Md. 21784  |  |   |  |  |  |  |  |   |  |  |  |
|  | 23a. Part I. Enter the disaasa, or complications that caused the daeth. Do not enter the moda of dying, such as cardiac or respiratory arrest,<br>shock, or haart failure. List only ona cause on each lina.<br>Immediate Cause (Final<br>disaasa or condition<br>resulting in death)<br>a. Acute Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Hypertension.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |   |   |   |   |  |   |  |  |  |  |  |   |  | Approximate<br>Interval Between<br>Onsat and Deeth |  |
|  | Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the undarying causa given in Part I.<br>Dementia |   |   |   |  |   |  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |   |   |   |   |   |  |   |  |  |  |  | 24a. Was an autopsy<br>performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 24b. Ware autopsy findings<br>available prior to<br>completion of cause<br>of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was casa rferred to medical<br>examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only ona)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Rasidence 8 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |  |  |  |   |  |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pandng<br>Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be<br>determined<br>3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida   |   | 28a. Date of Injury<br>(Month, Day Year)  |   | 28b. Time of<br>Injury<br>M   |  | 28c. Injury at<br>Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |  |  |   |  |  |  |
|  |   |   | 28a. Place of Injury - At home, farm, straet, factory, office<br>building, etc. (Specify)   |   |   |  |   |  | 28f. Location (Street and Number or Rural Routs Number,<br>City or Town, Stata)                    |  |  |  |   |  |  |  |
|  | 29a. Certifier<br>(Check only<br>one)<br>1 <input checked="" type="checkbox"/> Certifying Physictan: To the best of my knowledge, daeth occurred at the tima, data and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medicet Examiner: On the basis of axamination and/or Invastigation, in my opinion, daeth occurred at the tima, data and place, and dua to the cause(s)<br>end manner stated.                              |   |   |   |   |  |   |  |  |  |  |  |   |  |  |  |
|  | 29b. Signatura and titla of certifier<br>Anil Uberoi MD   |   |   |   | 29c. Licensa number<br>D96748   |  |   |  | 29d. Data signed (Month, Day, Year)<br>7/17/96   |  |  |  |   |  |  |  |
| State<br>Registrar   | 30. Nama and address of person who completed causa of daeth (Itam 23a) (Type, Print)<br>ANIL UBEROI MD 44K, FALLS RD BALTO MD 21211   |   |   |   |   |  |   |  |  |  |  |  |   |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>JUL 23 1996  |   |   |   | 32. Registrar's Signature<br>Julia Davidson-Rendell   |  |   |  |  |  |  |  |   |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

96 21722

Film G737 item 19a 7-23=96 rja

## Certificate of Death

Reg. No.

|  |  |  |   |   |   |                                |  |  |  |  |
|--|--|--|---|---|---|--------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Catherine C. Kalista   |  |   |   | 2. Date of Death<br>Month Day Year<br>July 18, 1996   |                                |  |  | 3. Time of Death<br>7:15 P.M.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>St. Martin's Home for the Aged   |  |   |   | 4b. City, Town, or Location of Death<br>Catonsville   |                                |  |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-03-3315   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>92 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>OCT 28, 1903                                  |  | 9. Birthplace (State or Foreign Country)<br>Baltimore MD   |  |
|  | Usual Residence of Decedent  |  |   |   |   |                                |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10e. State<br>Md   |  | 10b. County<br>Baltimore  |   | 10c. City, Town or Location<br>Catonsville  |                                |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>601 Maiden Choice Lane   |  |   |   | 10f. Zip Code<br>21228  |                                | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7th Grade  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cigar Maker  |                                |  | 16b. Kind of Business/Industry<br>Cigar Company                  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Anthony J. Jagr   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary A. Handrejch  |                                |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Joseph A. Anthony Jagr (Son) Kalista   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1105 Jade Drive - BelAir, Md 21014   |                                |  |  |  |  |
|  | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Most Holy Redeemer  |                                | Date<br>7/22/96  |  | 20c. Location - City or Town, State<br>Baltimore   |  |
|  | 21. Signature of Funeral Service Licensee<br>Jancy J. Thompson   |  |   |   | 22. Name and Address of Facility<br>Hubbard Funeral Home, Inc.<br>4107 Wilkens Avenue, Baltimore, MD 21229  |                                |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive heart failure<br>Due to (or as a consequence of):<br>b. Atherosclerotic Heart Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>5 yrs<br>15 yrs |  |   |   |   |                                |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Renal failure  |  |   |   |   |                                |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |  |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
|  |  |  |   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |                                |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |   |                                |  |  |  |  |
|  | 29b. Signature and Title of certifier<br>Sankaran  |  |   |   | 29c. License number<br>D21649   |                                |  | 29d. Date signed (Month, Day, Year)<br>7-19-96                   |  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Sambandam Baskaran 3455 Wilkens Avenue, Baltimore, MD 21229  |  |   |   |   |                                |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>JUL 23 1996   |  | 32. Registrar's Signature<br>Julia Davidson-Rendell   |   |   |                                |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 21723

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SYLVIA

KOHN

2. Date of Death

Month Day Year  
JULY 18, 1996

3. Time of Death

5:52AM

4a. Facility Name (If not institution, give street and number)

JEWISH CONVALESCENT HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

212-01-5747

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 21, 1905

9. Birthplace (State or Foreign Country)

BALTIMORE

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3809 CLARKS LANE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

BENJAMIN

MILLER

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

SNYDER

19a. Informant's Name/Relationship (Type, Print)

ARNOLD KOHN - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2300 SUGARCON ROAD BALTIMORE, MD 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

(ANSHE EMUNAH) AITZ CHAIM 7/19/96

Date

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

Ruth H. Leuner

22. Name and Address of Facility

Sol Levinson & Bros., Inc.  
8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. MYOCARDIAL INFARCTION.  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 MINUTE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CORONARY ARTERY OCCLUSION  
Due to (or as a consequence of):

5 MINUTES

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. [Signature] M.D.

29c. License number

1540

29d. Date signed (Month, Day, Year)

7/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Law Susting M.D.

8210 PK. Hts Bldg  
BALTIMORE MD 21215

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

96 21724

Certificate of Death

Reg. No.

|   |  |   |   |  |  |   |  |   |  |  |
|---|--|---|---|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Beatrice Klonin</u>   |   |   |  |  |   | 2. Date of Death<br>Month <u>July</u> Day <u>17</u> Year <u>96</u>     |   | 3. Time of Death<br><u>9:05 AM</u>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Howard County General Hospital</u>  |   |   |  |  |   | 4b. City, Town, or Location of Death<br><u>Columbia</u>                |   | 4c. County of Death<br><u>Howard</u>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>096-18-0039</u>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>72</u> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><u>June 11, 1924</u>            |   | 9. Birthplace (State or Foreign Country)<br><u>New York</u>  |  |
|   | Usual Residence of Decedent  |   |   |  |  |   |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><u>Md.</u>   |   | 10b. County<br><u>Howard</u>  |  | 10c. City, Town or Location<br><u>Columbia</u>   |   |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><u>5465 Gloucester Road</u>  |   |   |  | 10f. Zip Code<br><u>21044</u>  |   | 10g. Citizen of What Country?<br><u>U.S.A.</u>                         |   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>   |   |   |  | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Bookkeeper</u>   |   |  | 16b. Kind of Business/Industry<br><u>Construction Co.</u>               |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>Herman poplinger</u>   |   |   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Lena Bloom</u> |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><u>Arnold Klonin (Spouse)</u>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>5465 Gloucester Road Columbia, Maryland 21044</u>  |   |  |   |  |  |
|   | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other facility)<br><u>Md. Veterans Cemetery</u>  |   |  | 20c. Location - City or Town, State<br><u>Owings Mills, Maryland</u>    |  |  |
|   | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>  |   |   |  | 22. Name and Address of Facility<br><u>Witzke Funeral Home, Inc.</u><br><u>1630 Edmondson Avenue Catonsville, Maryland</u>   |   |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><u>Metastatic Lung Cancer</u><br>Due to (or as a consequence of):<br>b. <u></u><br>Due to (or as a consequence of):<br>c. <u></u><br>Due to (or as a consequence of):<br>d. <u></u> |   |   |  |  |   |  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |   |  |  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u></u>   |  |   |   |  |  |   |  |   |  |  |
| 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><u>M</u>                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred                                       |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><u>[Signature]</u>   |   | 29c. License number<br><u>D41274</u>             |  | 29d. Date signed (Month, Day, Year)<br><u>Jul 17, 1996</u>                                      |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Michael E Silverman Ho Co General Hospital Columbia, MD</u>  |  |   |   |  |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 23 1996</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |   |  |  |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21725

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Juliann Koppang

2. Date of Death

Month July Day 16, Year 1996

3. Time of Death

8:30 P M

4a. Facility Name (If not institution, give street and number)

13524 Argo Drive

4b. City, Town, or Location of Death

Dayton

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

501 28 3351

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Sept 8, 1932

9. Birthplace (State or Foreign Country)

N.D.

Usual Residence of Decedent

10a. State

Md.

10b. County

Howard

10c. City, Town or Location

Dayton

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

13524 Argo Drive

10f. Zip Code

21036

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

High School

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Credit Co.

17. Father's Name (First, Middle, Last)

Peter Dorsher

18. Mother's Name (First, Middle, Maiden Surname)

Clara Knutson

19a. Informant's Name/Relationship (Type, Print)

Paul Koppang

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13524 Argo Drive Dayton, Md. 21036

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Carroll Cremation

Date

7/18/96

20c. Location - City or Town, State

Hampstead, MD.

21. Signature of Funeral Service Licensee

Harry W. Haight

22. Name and Address of Facility

Haight Funeral Home

P.O. Box 195 Sykesville, Md. 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Metastatic Lung Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

N/A.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature]

29c. License number

D41139

29d. Date signed (Month, Day, Year)

7/17/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11055 Little Potomac Pkwy, Columbia, Md.

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

John [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





96 21726

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET M. LAVER</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>JULY</b> DAY <b>19</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>9:00 am</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-10-6481</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>NOV. 14, 1915</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WILMINGTON, DE</b>   |  |   |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |   |
| 9c. COUNTY OF DEATH<br><b>N/A</b>   |  |   |  |   |  |   |   |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>CATONSVILLE</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>701 MAIDEN CHOICE LANE</b>   |  |   |  | 10f. ZIP CODE<br><b>21228</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b> College (1-4 or 5+) <b>HOMEMAKER</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOMEMAKING</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES E. LEE</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Surname)<br><b>MARIE CLOPEIN</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOAN STITZ (NIECE)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1898 AUGUST AVENUE - BALTIMORE, MD 21222</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEMETERY 7/22</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALITMORE</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Nancy J. Thompson</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME, INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute anterior myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>DAYS</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Rapid, atrial fibrillation, Congestive heart failure.</b>  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Bernard F. Korlovsky</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D26473</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 13, 1996</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BERNARD F KORLOVSKY, MD 711 MAIDEN CHOICE LA 21228</b>  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 23 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This is to certify that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 21727

**Division of Vital Records, P.O. Box 68760,**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21728  
Certificate of Death

Reg. No.

|  |   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
|--|---|---|---|--------------------------------|--|--|--|-----------------------------------|--|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Harold C. Lynch   |   |   |                                | 2. Date of Death<br>Month Day Year<br>June 25, 1996  |  |  |                                   | 3. Time of Death<br>1430   |  |   |   |   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>VA Maryland Health Care System  |   |   |                                | 4b. City, Town, or Location of Death<br>Baltimore  |  |  |                                   | 4c. County of Death<br>N/A   |  |   |   |   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>224-28-0331  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                | 7. Age (In yrs. last birthday)<br>69 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>9-18-26                   |                                   | 9. Birthplace (State or Foreign Country)<br>N/A  |  |   |   |   |   |  |
|  | Usual Residence of Decedent   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD  |   | 10b. County<br>N/A  |                                | 10c. City, Town or Location<br>Baltimore   |  |  |                                   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |   |   |   |  |
|  | 10e. Street and Number<br>1608 W Pratt St   |   |   |                                | 10f. Zip Code<br>21223   |  | 10g. Citizen of What Country?<br>USA                             |                                   |  |  |   |   |   |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 10-42 7-43 |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                   |  |  |   |   |   |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)  |   |   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>unknown   |  | 16b. Kind of Business/Industry<br>unknown                        |                                   |  |  |   |   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>unknown  |   |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>unknown   |  |  |                                   |  |  |   |   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>VA Maryland HHA   |   |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10 North Greene St. Balto, MD 21201   |  |  |                                   |  |  |   |   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Harrison Forest Cemetery  |                                | 20c. Date<br>7-10-96   |  | 20d. Location - City or Town, State<br>Owings Mills Md           |                                   |  |  |   |   |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br>Ervin Carroll  |   |   |                                | 22. Name and Address of Facility<br>Ervin Carroll Funeral Home<br>1712-14 W North Ave Balto MD 21217   |  |  |                                   |  |  |   |   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
|  | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td rowspan="4">           {<br/>           a. Sepsis<br/>           Due to (or as a consequence of):<br/>           Tuberculosis/COPD<br/>           b.<br/>           Due to (or as a consequence of):<br/>           c.<br/>           Due to (or as a consequence of):<br/>           d.         </td> <td>Approximate Interval Between Onset and Death<br/>4 d</td> </tr> <tr> <td>?</td> </tr> <tr> <td></td> </tr> <tr> <td></td> </tr> </table> |   |   |                                |  |  |  |                                   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | {<br>a. Sepsis<br>Due to (or as a consequence of):<br>Tuberculosis/COPD<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. | Approximate Interval Between Onset and Death<br>4 d | ? |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | {<br>a. Sepsis<br>Due to (or as a consequence of):<br>Tuberculosis/COPD<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.   | Approximate Interval Between Onset and Death<br>4 d |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
|  |   | ?   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
|  |   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
|  |   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)              |   | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred |  |  |   |   |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier               |   | 29c. License number<br>1310368 |  | 29d. Date signed (Month, Day, Year)<br>6/25/96                                       |  |                                   |  |  |   |   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>David Lambert, 22 South Greene Street, Baltimore, MD 21201   |   |   |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996   |   | 32. Registrar's Signature<br>[Signature]            |   |                                |  |  |  |                                   |  |  |   |   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21729  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irving Levy

2. Date of Death

July 20 1996

3. Time of Death

0120

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

219-01-2324

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 17, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15 Beacon Court

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pharmacist

16b. Kind of Business/Industry

Medicine

17. Father's Name (First, Middle, Last)

Louis Levy

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Zell

19a. Informant's Name/Relationship (Type, Print)

Esther Levy

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Beacon Court, Annapolis, MD 21403

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

7/23

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

James H. Hardesty

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Ave. Annapolis, MD 21401

23a. Pertinent, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Congestive Heart Failure

Due to (or as a consequence of):

b.

Ischemic Cardiovascular Pathology

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatic Failure

Cerebral Anoxia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Biern M.D.

29c. License number

D00561

29d. Date signed (Month, Day, Year)

JUL 22, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Biern 900 Bestgate, Annapolis, MD

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

Don Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21730

|   |   |   |  |  |  |  |   |  |
|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM JOHN LUCAS</b>   |   |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>20</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>3:35PM</b>                                       |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Good Samaritan Hospital</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-07-8923</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 20, 1920</b>             | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |
|   | Usual Residence of Decedent   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore City</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 10e. Street and Number<br><b>3821 Bayonne Avenue</b>  |   |  |  | 10f. Zip Code<br><b>21206</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>9/29/42-8/25/44</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 Years</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>   |  |  | 16b. Kind of Business/Industry<br><b>City of Baltimore</b>   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Joseph Anthony Lucas</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ursula Unknown Anderson</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Anna Mary Lucas / Wife</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3821 Bayonne Avenue, Baltimore, Maryland 21206</b>   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>   |  | Date<br><b>7/24/96</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>       |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |  |  | 22. Name and Address of Facility<br><b>John C. Miller, Inc.<br/>6415 Belair Road, Baltimore, Maryland 21206</b>  |  |   |  |
|   | 23a. Part I: Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Sepsis</b><br>Due to (or as a consequence of):<br>b. <b>Disseminated INTRAVASCULAR COAGULOPATHY</b><br>Due to (or as a consequence of):<br>c. <b>Respiratory FAILURE</b><br>Due to (or as a consequence of):<br>d. <b>SHOCK LIVER</b> |   |  |  |  |  |   |  |
|   | 23b. Part II: Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Approximate Interval Between Onset and Death<br><b>3 days</b><br><b>2 days</b><br><b>2 days</b><br><b>2 days</b>  |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |
|   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Z. Musselmani M.D.</b>  |  | 29c. License number<br><b>pg 3401</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>July 20, 1996</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Zattam Musselmani<br/>5601 Loch Raven Blvd, Baltimore, MD 21239</b>  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |   | 32. Registrar's Signature<br>   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21731

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 502-68.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate is signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM A. MILLER</b>  |  |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>17</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>1155 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| 5. Social Security Number<br><b>264-82-7396</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 13, 1947</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>RALEIGH, N.C.</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>12832 SAND DOLLAR WAY</b>  |  | 10f. Zip Code<br><b>21220</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 YRS</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MANAGER</b>   |  | 16b. Kind of Business/Industry<br><b>RETAIL</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>DONALD ROBERT MILLER</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Summa)<br><b>MARGARET GLENN</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>WILLIAM ALBRIGHT AZEVEDO (SON)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>453 NE 210 TERRACE - MIAMI, FLORIDA 33179</b>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HOLIDAYSBURG PRESBYTERIAN CEM.</b>   |  | 20c. Location - City or Town, State<br><b>HOLIDAYSBURG, PA</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Jancy J. Thompson</b>  |  | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME, INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Cause (Final disease or condition resulting in death)<br><b>a. LUNG CARCINOMA</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>12 MONTHS</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. Signature and title of certifier<br><b>J. Chawla House Officer</b>   |  | 29c. License number<br><b>AS 2441616</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 18, 1996</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JASVINDER P.S. CHAWLA 3001 SOUTH HANOVER ST., BALTIMORE, MD-21225</b>   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |  |

State Registrar



96 21732

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Laura Elizabeth Marable</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>07</b> DAY <b>21</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>4:00 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-20-6921</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>October 29, 1911</b>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Nursing Home</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore, Maryland</b>   |  | 9c. COUNTY OF DEATH<br><b>N/A</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1601 E. Belvedere Avenue</b>   |  | 10f. ZIP CODE<br><b>21239</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b><br>College (1-4 or 5+) <b>N/A</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Domestic</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Jones</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maggie Freeling</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Florence Jones</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4503 Monardene Rd, Baltimore Md. 21229</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Maryland National Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Laurel, Maryland</b>  |  | 20d. DATE<br><b>July 25, 1996</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Carlton C. Dargatzis</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Douglas Funeral Service</b><br><b>1701 McCulloh Street, Baltimore, Md. 21217</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>cerebrovascular accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Insulin Dependent Diabetes</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>gastrostomy feeding tube</b> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Suresh K. Tripuraeni</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 30661</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 22nd 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SURESH K. TRIPURANI, 1601 Belvedere, Baltimore, Md - 21239</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 23 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>James A. Wilson-Randall</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21733

|  |   |  |   |  |   |  |   |  |
|--|---|--|---|--|---|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>     | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Mazer</b>   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>16</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>12:15 am</b>                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>STELLA MARIS HOSPICE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>                                 |  |
| <b>Funeral<br/>Director</b>                    | 5. Social Security Number<br><b>216-14-7326</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 3, 1923</b>              |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>BALTIMORE</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>OWINGS MILLS</b>                      |  |
| <b>To Be Completed by<br/>Funeral Director</b> | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 10e. Street and Number<br><b>10 SIERRA CIRCLE APT. H</b>  |  |   |  |
|  | 10f. Zip Code<br><b>21117</b>   |  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>NAVY</b><br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+) <b>Collage</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALESPERSON</b>   |  | 16b. Kind of Business/Industry<br><b>HOME IMPROVEMENTS</b>              |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>LOUIS MAZER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSE COHEN</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DORIS SINGER - SISTER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>400 E. 56TH ST #6-P NEW YORK, NY 10022</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH EL MEMORIAL PARK</b>  |  | 20c. Date<br><b>7/21/96</b>   |  | 20d. Location - City or Town, State<br><b>RANDALLSTOWN</b>              |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><b>Sol Levinson &amp; Bros., Inc.<br/>8900 Reisterstown Road Pikesville, MD 21208</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>CHRONIC ASPIRATION PNEUMONIA</b></p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>b. <b>CHRONIC LUNG DISEASE</b></p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>c. _____</p> <p style="text-align: center;">Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>recently</b></p> <p><b>hrs.</b></p> </div> </div> |  |   |  |   |  |   |  |

|   |  |  |  |
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| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>H/O Head and neck Cancer</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |

|  |  |   |  |
|--|--|---|--|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  |
|  |  | 28b. Time of Injury<br><b>1</b> Yes <b>2</b> No   |  |
|  |  | 28c. Describe how injury occurred<br><b>28d. Location (Street and Number or Rural Route Number, City or Town, State)</b>  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><b>D25643</b>  |  |
|  |  | 29d. Date signed (Month, Day, Year)<br><b>7/16/96</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kendall Faulkner, M.D. 2300 Dulaney Valley Road, Towson, MD 21204</b>   |  |   |  |

|   |  |   |  |
|---|--|---|--|
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b> |  | 32. Registrar's Signature<br><i>[Signature]</i> |  |
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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Catherine E. Moran   |  |  |  | 2. DATE OF DEATH<br>MONTH July DAY 15, YEAR 1996   |  |   |  | 3. TIME OF DEATH<br>8:30 PM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>212-18-5518   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>82 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 25, 1913                               |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Manor Care Nursing Home  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson  |  |   |  | 9c. COUNTY OF DEATH<br>Baltimore   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |  |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>2110 Gaylawn Drive   |  |  |  | 10f. ZIP CODE<br>21227   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: White |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home                       |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Unknown Haines  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elizabeth Unknown   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mary P. McKenna (Daughter)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5812 Judge Dobbin Court Baltimore, Maryland 21227   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Specify cemetery, crematory or other place)<br>Lorraine Park Cemetery July 19, 1996  |  |   | 20c. LOCATION — City or Town, State<br>Woodlawn, Maryland        |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Witzke Funeral Home, Inc.<br>1630 Edmondson Avenue Catonsville, Maryland   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → End-Stage Lymphoma<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |   |  | Approximate interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br>D42736  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>7-17-96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Form 47) (Type, Print)<br>Ayman Akkad, M.D. 7600 Osler Dr. - Towson, Maryland 21204   |  |  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>Jul 23 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR AT THE PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21735

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>GERARD MOORE   |  |   |  | 2. Date of Death<br>Month Day Year<br>JULY 18, 1996  |  | 3. Time of Death<br>7:55 PM   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br>UNIVERSITY HOSPITAL S.T.U  |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>N/A  |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-78-6228   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>36 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>JULY 28, 1959                            |  |
|  | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  | 10a. State<br>MARYLAND  |  | 10b. County<br>N/A   |  | 10c. City, Town or Location<br>BALTIMORE CITY                                   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br>1404 MADISON AVENUE   |  | 10f. Zip Code<br>21217   |  | 10g. Citizen of What Country?<br>U.S.A.   |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) N/A<br>College (1-4 or 5+) 3 YEARS  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>JR. PRESSMAN                         |  | 16b. Kind of Business/Industry<br>BALTIMORE SUN PAPER  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>JAMES CALVIN MOORE  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>AUDREY DEAN   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>KAREN SMITH-SISTER   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5 WELL HAVEN CIRCLE APT. 1131 OWINGS MILLS, MD. 21117                                       |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ARBUTUS MEMORIAL PARK   |  | 20c. Location - City or Town, State<br>JULY 24, 1996 BALTO, MD.  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>Calvin B. Scruggs Jr.   |  | 22. Name and Address of Facility<br>CALVIN B. SCRUGGS FUNERAL HOME<br>1412 E. PRESTON ST. BALTO, MD. 21213  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cutting Wound of Right Arm<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 28a. Date of Injury (Month, Day, Year)<br>7-18-96  |  | 28b. Time of Injury<br>1910 M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>subject cut arm on broken glass door panel |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>AT HOME  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>1404 Madison Ave  |  |  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |
|  | 29b. Signature and title of certifier<br>D. B. Locke M.D.  |  | 29c. License number<br>O.C.M.E  |  | 29d. Date signed (Month, Day, Year)<br>JULY 20, 1996   |  |   |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br>JUL 23 1996   |  | 32. Registrar's Signature<br>[Signature]  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attorney: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21736  
Certificate of Death

Reg. No.

|  |  |  |   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|--|--|--|---|---|--|--|--|---|---|----|------------|--|----------------------------------|--|----|-------------------------|----------------------------------|--|--|----|-------------------------|---------|----------------------------------|--|----|--|---------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>HARRY H. NADOLSKI  |  |   |   | 2. Date of Death<br>Month Day Year<br>JULY 17, 1996  |  | 3. Time of Death<br>7:25 A.M.                                    |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>5004 BARTON AVENUE   |  |   |   | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>BALTIMORE CITY                            |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-32-4844   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>60 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>MAY 13, 1936  |  | 9. Birthplace (State or Foreign Country)<br>BALTIMORE, MARYLAND   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | Usual Residence of Decedent  |  |   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND   | 10b. County<br>BALTIMORE CITY  | 10c. City, Town or Location<br>BALTIMORE  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | 10e. Street and Number<br>5004 BARTON AVENUE   |  |   | 10f. Zip Code<br>21206  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: KOREA |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) UNKNOWN<br>College (1-4 or 5+) UNKNOWN  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>LIMOUSINE SERVICES                             |   |  | 16b. Kind of Business/Industry<br>SELF EMPLOYED  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>ANDREW MONAIRUI   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARGARET WEBSTER  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>WAYNE M. MILLER (STEP SON)   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5004 BARTON AVENUE BALTIMORE, MARYLAND 21206  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>METRO CREMATORY, INC. JULY 20, 1996   |   | Data   |  | 20c. Location - City or Town, State<br>BALTIMORE, MARYLAND       |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Wayne M. Miller</i>  |  |   |   | 22. Name and Address of Facility<br>LASSAHN FUNERAL HOME, INC.<br>7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>arrhythmia</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>ischemic cardiomyopathy</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td>coronary artery disease</td> <td rowspan="3">minutes</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>2 years</td> </tr> <tr> <td colspan="2"></td> <td></td> <td>&gt; 5 years</td> </tr> </table> |  |   |   |  |  |  |   | Immediate Cause (Final disease or condition resulting in death) | a. | arrhythmia | Approximate Interval Between Onset and Death | Due to (or as a consequence of): |  | b. | ischemic cardiomyopathy | Due to (or as a consequence of): |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. | coronary artery disease | minutes | Due to (or as a consequence of): |  | d. |  | 2 years |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  | a.   | arrhythmia   | Approximate Interval Between Onset and Death  |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | Due to (or as a consequence of):   |  |   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | b.   | ischemic cardiomyopathy  |   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | Due to (or as a consequence of):   |  |   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | c.   | coronary artery disease  | minutes   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | Due to (or as a consequence of):   |  |   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  | d.   |  |   | 2 years   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  |  |  | > 5 years   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>diabetes mellitus  |  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
|  |  |  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.   |  |  |   | 29c. License number<br>96007  |  | 29d. Date signed (Month, Day, Year)<br>7/19/96   |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DANIEL HALEVY MD, 4940 EASTERN AVENUE, BALTIMORE MD 21224  |  |  |   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996   |  | 32. Registrar's Signature<br><i>[Signature]</i>                                |   |   |  |  |  |   |   |    |            |  |                                  |  |    |                         |                                  |  |  |    |                         |         |                                  |  |    |  |         |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21737

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma A. Newcomer

2. Date of Death

Month Day Year  
July 22, 1996

3. Time of Death

1330

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Homewood

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-16-3432

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jun 22, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co

10c. City, Town or Location

Timonium

10d. Include City Limits

☒ Yes ☐ No

10e. Street and Number

12 Tully Cross Court

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Arthur Allen

18. Mother's Name (First, Middle, Maiden Surname)

Mary Wheeler

19a. Informant's Name/Relationship (Type, Print)

Ron Newcomer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Tully Cross Court, Timonium, Md 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Church St. Marys Episcopal Cem

Date

7/24/96

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home

3818 Roland Avenue, Baltimore, Md. 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumonia

malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carl Sperling, M.D.

29c. License number

D28987

29d. Date signed (Month, Day, Year)

7-22-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CARL SPERLING, M.D. 5601 LOCK RAVEN BLVD BALTIMORE MD 21239

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar (Signature)

John R. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21738

## Certificate of Death

Reg. No.

|  |  |   |  |   |   |   |   |  |
|--|--|---|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GRACE V. PICKEL</b>   |   |  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>20</b> Year <b>96</b>  |   | 3. Time of Death<br><b>3:35A</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Church Home Hospital</b>  |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-74-9267</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 23, 1912</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10. Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                        |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Funeral Director  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                       |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |
|  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>John F. Debelius</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida E. Duvall</b>   |   | 19. Informant's Name/Relationship (Type, Print)<br><b>Barbara P. Daniel (Daughter)</b>  |  |
| Physician<br>/Medical<br>Examiner  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>7-23-96 Baltimore, Maryland</b>   |   | 21. Signature of Funeral Service Licensee<br>   |  |
|  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home<br/>3331 Brehms Lane, Baltimore, Maryland 21213</b>  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Extensive Carcinomatosis abdomen</b> |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |
|  | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>   |  |
|  | 29c. License number<br><b>D17005</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>7/20/96</b>  |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. GOPAL GURASWAMY MD Church Home Hospital BALTIMORE MD 21231</b>   |   | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  |
| 32. Registrar's Signature<br>  |  | 33. State Registrar<br><b>JUL 23 1996</b> |  | 34. State Registrar<br><b>JUL 23 1996</b> |   | 35. State Registrar<br><b>JUL 23 1996</b> |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21739

|   |   |  |   |  |   |  |  |  |   |  |
|---|---|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Houston Reed Puckett, Jr  |  |   |  | 2. Date of Death<br>Month Day Year<br>July 20, 1996   |  |  |  | 3. Time of Death<br>0830 AM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>2338 Hoover Lane  |  |   |  | 4b. City, Town, or Location of Death<br>Glen Arm  |  |  |  | 4c. County of Death<br>BALTIMORE  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>216-30-0967  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F<br>X   |  | 7. Age (In yrs. last birthday)<br>64 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>July 26, 1931                                 |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND  |  |
|   | Usual Residence of Decedent   |  |   |  | 10e. State<br>MARYLAND  |  |  |  | 10b. County<br>BALTIMORE  |  |
| To Be Completed by Funeral Director           | 10c. City, Town or Location<br>GLEN ARM   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   |  |
|   | 10e. Street and Number<br>2338 Hoover Lane  |  |   |  | 10f. Zip Code<br>21057  |  |  |  | 10g. Citizen of What Country?<br>USA  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Engineer   |  |  |  | 16b. Kind of Business/Industry<br>Defense (AAI)   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Houston Reed Puckett, Sr.  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Bryant   |  |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Jeanette D. Puckett   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2338 Hoover Lane, Glen Arm, MD 21057   |  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Druid Ridge Cemetery  |  | Date<br>23 JULY   |  | 20c. Location - City or Town, State<br>Pikesville, MD                                |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>Bryan W. Clary   |  |   |  | 22. Name and Address of Facility<br>Lemmon Funeral Home of Dulaney Valley, Inc.<br>10 W. Padonia Rd., Timonium, MD 21093  |  |  |  |   |  |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. PROSTATE CANCER<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28e. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
|   | 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. Signature and title of certifier<br>G I U  |  |  |  | 29c. License number<br>D 27730  |  |
| State Registrar                               | 29d. Date signed (Month, Day, Year)<br>July 22, 1996  |  |   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Gary Cohen, M.D. 6569 N. Charles St., suite 205, Baltimore, MD 21204  |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br>JUL 28 1996  |  |   |  | 32. Registrar's Signature<br>John L. ...  |  |  |  |   |  |

15 + UVA



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21740

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anthony PLEWACKI

2. Date of Death

Month Day Year  
July 21, 1996

3. Time of Death

10:50 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

5. Social Security Number

218-05-4893

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 7, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

53 Fenway North

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Woodworking

17. Father's Name (First, Middle, Last)

Stanislaus plewacki

18. Mother's Name (First, Middle, Maiden Surname)

Veronica Macek

19a. Informant's Name/Relationship (Type, Print)

Agnes Plewacki

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

53 Fenway North Apt. A Baltimore Md. 21221

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Stanislaus Cemetery 7/24/96

Date

20c. Location - City or Town, State

Baltimore MD.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex  
300 Mace Ave. Baltimore Md. 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Aortic aneurysm

Due to (or as a consequence of):

3 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

obstructive lung disease (emphysema)

Asbestosis

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

28. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. Stuart Willes, M.D.

29c. License number

D36663

29d. Date signed (Month, Day, Year)

July 21, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Stuart Willes 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 23a is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

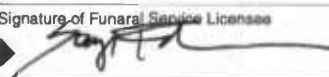
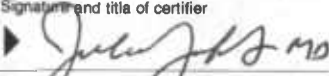
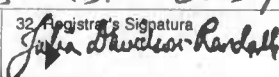
Medical Certification: To Be Completed by Physician/Medical Examiner



Certificate of Death

Reg. No.

96 21741

|  |  |   |   |  |  |  |
|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>IDA G. POMERANTZ</b>  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>19</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>12:10pm</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5715 PARK HEIGHTS AVENUE APT. 705</b>   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-38-5009</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.   |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>MAR.10, 1898</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>RUSSIA</b>   |  |  |  |
| To Be Completed by<br>Funeral Director   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |  |
|  | 10e. Street and Number<br><b>5715 PARK HEIGHTS AVE, APT. 705</b>   |   | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:       |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+)                            |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |  |
|  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>MORRIS LEVINE</b>   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>LENA SLUTSKY</b>   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. ELINOR WEIL (DAUGHTER)</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3011 FALLSTAFF RD, APT.608; BALTIMORE, MD 21209</b> |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SHAAREI ZION</b>   |  | 20c. Location - City or Town, State<br><b>7-22-96 BALTIMORE, MD</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Sol Levinson &amp; Bros., Inc.<br/>8900 Reisterstown Road Pikesville, MD 21208</b>                               |  |  |  |
|  | 23a. (Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.)<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CARDIO-PULMONARY ARREST</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death<br><b>IMMEDIATE</b>  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>025039</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>7.19.96</b>                        |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JULIAN JAKOROVITS MD. 6503 PARK HgHs. AVE BALT. MD 21215</b>  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |  | 32. Registrar's Signature<br>  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general  
description of the project and its objectives.

2. The second part of the report is a detailed  
description of the methodology used in the study.

3. The third part of the report is a detailed  
description of the results of the study.

4. The fourth part of the report is a detailed  
description of the conclusions of the study.

5. The fifth part of the report is a detailed  
description of the recommendations of the study.

6. The sixth part of the report is a detailed  
description of the limitations of the study.

7. The seventh part of the report is a detailed  
description of the future research.

8. The eighth part of the report is a detailed  
description of the references.

9. The ninth part of the report is a detailed  
description of the appendices.

10. The tenth part of the report is a detailed  
description of the index.

11. The eleventh part of the report is a detailed  
description of the bibliography.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21742

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emma Ulrich Rye

2. Date of Death

Month Day Year  
July 20, 1996

3. Time of Death

7:15 A.M.

4a. Facility Name (If not institution, give street and number)

4100 Baker Lane

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-28-3901

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
July 19, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4100 Baker Lane

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Henry Ulrich

18. Mother's Name (First, Middle, Maiden Surname)

Louisa K. Breeback

19a. Informant's Name/Relationship (Type, Print)

Jacob Rye (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4100 Baker Lane, Baltimore, MD 21236

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

7/23/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schmunek Funeral Homes, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Dis.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Generalized Arteriosclerosis

Due to (or as a consequence of):

20 years.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes II  
Essential Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ OOA

Other:

☒ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicida ☐ Homicida

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore E. Evans MD

29c. License number

D01340

29d. Date signed (Month, Day, Year)

7-22-96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Theodore E. Evans, 9660 Belair Rd., Baltimore, MD 21236

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

Judy W. Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



96 21743

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>JOHN C. RICHARDSON Sr.</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>JULY</u> DAY <u>21</u> YEAR <u>96</u>  |  | 3. TIME OF DEATH<br><u>4:25 P M</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>157-01-2651</u>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>81</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>April 6 1915</u>                               |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Virginia</u>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Charlestown Care Center</u>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Catonsville</u>                                   |  |
| 9c. COUNTY OF DEATH<br><u>Baltimore</u>   |  |  |  | 10a. STATE<br><u>Maryland</u>   |  |   |  |
| 10b. COUNTY<br><u>Baltimore</u>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><u>Catonsville</u>   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><u>717 Maiden Choice Lane ST 316</u>  |  |   |  |
| 10f. ZIP CODE<br><u>21228</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u>                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>4</u> College (1-4 or 5+) <u>4</u>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Salesman</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Federal Government</u>                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>John C. Richardson</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Lillie Margaret Lipscomb</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Betty Jo Richardson</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>717 Maiden Choice Lane, ST 316, Catonsville, MD 21228</u>                                   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Chesapeake Crematory</u>   |  | DATE<br><u>7/23</u>   |  | 20c. LOCATION — City or Town, State<br><u>Beltsville MD</u>                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>HUBBARD FUNERAL HOME, INC.</u><br><u>4107 Wilkens Ave, Baltimore, MD 21229</u>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>UROSEPSIS</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>DIABETES MELLITUS, HYPERTENSION</u><br><u>PARKINSON'S</u><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28e. DESCRIBE HOW INJURY OCCURED  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |   |  |
| 29c. LICENSE NUMBER<br><u>D26473</u>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>JULY 22, 1996</u>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>BERNARD F KOZLOVSKY, MD 711 MAIDEN CHOICE LANE, 21228</u>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>JUL 23 1996</u><br>REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be enclosed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21744

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN E. RILEY

2. Date of Death

Month  
JULYDay  
20,Year  
1996

3. Time of Death

0252 AM

4a. Facility Name (If not institution, give street and number)

ST. MARY'S HOSPITAL

4b. City, Town, or Location of Death

LEONARDTOWN

4c. County of Death

ST. MARY'S

Funeral  
Director

5. Social Security Number

181-34-2068

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

50

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 24, 1945

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

Pa

10b. County

Greene

10c. City, Town or Location

Carmichaels

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

Ceylon Road, P.O. Box 162

10f. Zip Code

15320

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Delivery Person

16b. Kind of Business/Industry

Soft Drink Distr.

17. Father's Name (First, Middle, Last)

Bruce Riley

18. Mother's Name (First, Middle, Maiden Surname)

Opal Watters

19a. Informant's Name/Relationship (Type, Print)

Eileen Faye Riley/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 162, Carmichaels, Pa 15320

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Muddy Creek Cemetery

Date

7/25/96 Green County, Pa

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling Ashton Funeral Home, Inc  
736 Edmondson Avenue, Balto, Md 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Thrombosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 20, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryann R. Koser 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delivered for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document discusses the importance of maintaining accurate records of all transactions.

2. It is essential to ensure that all data is entered correctly and that the system is regularly updated.

3. The second part of the document outlines the procedures for handling customer inquiries and complaints.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21745

|   |   |   |   |                          |  |   |                                |                                   |  |   |  |   |   |  |  |
|---|---|---|---|--------------------------|--|---|--------------------------------|-----------------------------------|--|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Winifred May Rogers</b>  |   |   |                          | 2. Date of Death<br>Month <b>July</b> Day <b>21</b> Year <b>1996</b>   |   |                                |                                   | 3. Time of Death<br><b>11:25 PM</b>  |   |  |   |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Cherrywood Manor Nursing &amp; Conv. Center</b>  |   |   |                          | 4b. City, Town, or Location of Death<br><b>Reisterstown</b>  |   |                                |                                   | 4c. County of Death<br><b>Baltimore</b>  |   |  |   |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-78-4114</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                          | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |   | If Under 1 Year<br>Months Days |                                   | If Under 24 Hrs.<br>Hours Min.   |   | 8. Date of Birth (Month, Day, Year)<br><b>May 16, 1912</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |
|   | Usual Residence of Decedent   |   |   |                          |  |   |                                |                                   |  |   |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>  |   | 10b. County<br><b>Baltimore</b>   |                          | 10c. City, Town or Location<br><b>Reisterstown</b>   |   |                                |                                   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |   |  |  |
|   | 10e. Street and Number<br><b>101 Chartley Drive</b>   |   |   |                          | 10f. Zip Code<br><b>21136</b>  |   |                                |                                   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |   |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |                                |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |   |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |   |   |                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |   |                                |                                   | 16b. Kind of Business/Industry<br><b>Homemaker</b>   |   |  |   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Samuel Warfield</b>   |   |   |                          | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Della Stuller</b>  |   |                                |                                   |  |   |  |   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ernest C. Rogers, Jr.</b>  |   |   |                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5130 Byerly Rd., Upperco, Md. 21155</b>  |   |                                |                                   |  |   |  |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Snydersburg Cemetery July 25, 1996 Hampstead, Md.</b>                |                          |  |   | Date                           |                                   | 20c. Location - City or Town, State  |   |  |   |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |                          | 22. Name and Address of Facility<br><b>Eckhardt Funeral Chapel</b><br><b>11605 Reisterstown Rd., Owings Mills, Md. 21117</b>   |   |                                |                                   |  |   |  |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |   |   |                          |  |   |                                |                                   |  |   |  |   | Approximate Interval Between Onset and Death                |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. <b>CANCER PANCREAS</b><br>Due to (or as a consequence of):  |   |   |                          |  |   |                                |                                   |  |   |  |   | 2 MONTHS  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>f.<br>Due to (or as a consequence of):<br>g.<br>Due to (or as a consequence of):<br>h.<br>Due to (or as a consequence of):  |   |   |   |                          |  |   |                                |                                   |  |   |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |                          |  |   |                                |                                   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |
|   |   |   |   |                          |  |   |                                |                                   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |                          |  |   |                                |                                   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)     |   | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                | 28d. Describe how injury occurred |  |   |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br> |   |                          |  | 29c. License number<br><b>135606</b>  |                                |                                   |  | 29d. Date signed (Month, Day, Year)<br><b>7/22/96</b> |  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SAMUEL L. CROSSROADS JR. OWINGS MILLS MD 21117</b>   |   |   |   |                          |  |   |                                |                                   |  |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |   |   |   |                          |  |   |                                |                                   |  |   |  | 32. Registrar's Signature<br>   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MINA

2. Date of Death

Month Day Year  
JULY 20 1996

3. Time of Death

12 05 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6 REGALIA COURT APT. F

4b. City, Town, or Location of Death

OWINGS MILLS

4c. County of Death

BALTIMORE

5. Social Security Number

102-52-1338

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

95 94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG 26 1901

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

6 REGALIA COURT APT. F

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOSHUA MOSES GRUESS

18. Mother's Name (First, Middle, Maiden Surname)

TEMA WINKLER

19a. Informant's Name/Relationship (Type, Print)

LEO REINER - HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 REGALIA CT #F OWINGS MILLS, MD 21117

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT HEBRON QUEENS, NY

Date

7/22/96

20c. Location - City or Town, State

FLUSHING, QUEENS, NY

21. Signature of Funeral Service Licensee

Jay Allen Lewis

22. Name and Address of Facility

Sol Levinson & Bros., Inc.  
8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. dehydration  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. gastrointestinal bleed  
Due to (or as a consequence of):

1 year

c. colon cancer  
Due to (or as a consequence of):

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atherosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicida 4 ☐ Homicida

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Richard A Berg, MD

29c. License number

D20604

29d. Date signed (Month, Day, Year)

7/20/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Richard A Berg, MD #450, 10755 Falk Rd., Lutherville, Md 21093

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

J. A. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21747

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Anna Swam

2. Date of Death

Month Day Year  
July 19, 1996

3. Time of Death

8:00 P.M.

4a. Facility Name (If not institution, give street and number)

9359 Hines Estate Drive

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-03-1874

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 25, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9538 Gunhill Circle

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Frederick Lang

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Beitler

19a. Informant's Name/Relationship (Type, Print)

Donald E. Swam (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2501 Boston Street, Baltimore, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion Meth. Ch. Cem.

Date

7/23/96

20c. Location - City or Town, State

Freeland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schmunek Funeral Homes, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. CHRONIC LYMPHOCYTIC LEUKEMIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

9 YR.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY

DISEASE

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D14623

29d. Date signed (Month, Day, Year)

7/22/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN A. NESBITT III 5.526 200 E. 33RD ST. BALT., MD. 21218

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 21748

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edna Satterfield</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 18 1996</b>   |  | 3. TIME OF DEATH<br><b>4:00pm</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-30-6941</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 11, 1929</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1815 Steven Drive</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Edgewood</b>  |  | 9c. COUNTY OF DEATH<br><b>Harford</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Harford</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Edgewood</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1815 Steven Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>21040</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerical</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Social Security</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Otis George Jett</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Helen Irene Cavey</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jerry Lee Satterfield</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1815 Steven Drive Edgewood Md. 21040</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Cemetery 7/22/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. Terry Connelly</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Essex</b><br><b>300 Race Ave. Baltimore MD 21221</b>  |  |   |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode or type of death, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Myocardial Infarction</b><br><b>Atherosclerotic Cardiovascular disease</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Ashtma</b> |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>H38022</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 19 1996</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Peter Loreti, DO CARD 1308 Business Center Edgewood MD</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 23 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



7/23/96 t.t

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21749

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE B. SCHNESSEL

2. Date of Death  
Month Day Year  
JULY 18, 19963. Time of Death  
11:15am

4a. Facility Name (If not institution, give street and number)

HERITAGE NURSING CENTER

4b. City, Town, or Location of Death

DUNDALK

4c. County of Death

BALTIMORE

Funeral  
Director5. Social Security Number  
219-58-1836  
820-06-31436. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
88 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
MARCH 11, 19089. Birthplace (State or Foreign Country)  
GERMANY

Usual Residence of Decedent

10a. State  
MD10b. County  
N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3106 BANCROFT ROAD APT. B

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

VICTOR

ARNDT

18. Mother's Name (First, Middle, Maiden Surname)

BEATTE

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

HERMAN SCHNESSEL - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

812 UMBRA STREET BALTIMORE, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW HAR SINAI

Date

7/21/96

20c. Location - City or Town, State

REISTERSTOWN, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sol Levinson &amp; Bros., Inc.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Breast Cancer

Due to (or as a consequence of):

b. metastasis to lung

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to Immediate Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration

Hx of atrial arrhythmia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)29b. Signature and title of certifier  
Willarda V Edwards, M.D.

29c. License number

D21696

29d. Date signed (Month, Day, Year)

7/18/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLARDA EDWARDS, M.D. 1005 N. POINT BLVD SUITE 724 BALTIMORE, MD 21224

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

John Andrew Randall

State  
Registrar





7/23/96 tt

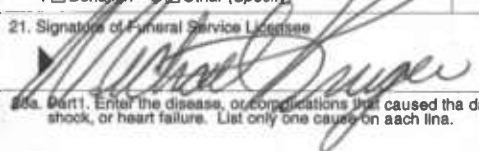
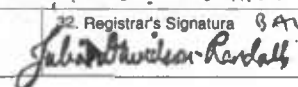
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21750

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SIDNEY SHERMAN</b>   |   |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>19</b> , Year <b>1996</b>   |  | 3. Time of Death<br><b>11:54 A.M.</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-12-2860</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>JAN. 1, 1919</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>RUSSIA</b>  |  |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>REISTERSTOWN</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br><b>9 TIMBER WAY CT.</b>   |   |   |  | 10f. Zip Code<br><b>21136</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>TOOL DESIGNER</b>                          |  | 16b. Kind of Business/Industry<br><b>WESTERN ELECTRIC</b>  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><del>LAID</del> <b>LEIB SHERMAN</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LEAH UNKNOWN</b>   |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. RUTH SHERMAN (WIFE)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 TIMBER WAY CT. REISTERSTOWN, MD 21136</b>  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHEVRA AHAVAS CHESED</b>   |  | Data<br><b>7/21/96</b>   |  | 20c. Location - City or Town, State<br><b>RANDALLSTOWN, MD</b>                                 |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CARDIOGENIC SHOCK</b><br>Due to (or as a consequence of):<br>b. <b>ACUTE RENAL FAILURE</b><br>Due to (or as a consequence of):<br>c. <b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br>d.  |   |   |   |  |  |  |  | <b>TWELVE HOURS</b><br><b>TWENTY-FOUR HOURS</b><br><b>TWENTY-FOUR HOURS</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |   |   |   |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |   |   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>  |   | 29c. License number                              |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 19, 1996</b>                      |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARCEJ LESNIAK, M.D. JOHNS HOPKINS HOSPITAL, 600 N. WOLFE ST., BALTIMORE, MD 21205</b>   |   |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |   | 32. Registrar's Signature<br>  |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21751

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OLGA SINGER

2. Date of Death

Month  
JULYDay  
20Year  
96

3. Time of Death

5:20 PM

4a. Facility Name (If not institution, give street and number)

LEVINDALE NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

064-34-5155

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JULY 23, 1903

9. Birthplace (State or Foreign Country)

HUNGARY

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2500 W. BELVEDERE AVE. APT. 227

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

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To Be Completed by Funeral Director

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOSEPH

ZEIGLER

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

SIDNEY SINGER - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7621 CARLA ROAD BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT HOPE - HASTINGS

Date

7/22/96

20c. Location - City or Town, State

HASTINGS ON HUDSON, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sol Levinson &amp; Bros., Inc.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *cardiovascular insufficiency*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Diabetes mellitus*

Due to (or as a consequence of):

c. *Diabetes mellitus*

Due to (or as a consequence of):

d. *Diabetes mellitus*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Circumstances

Circumstances

Circumstances

Circumstances

Circumstances

Circumstances

Circumstances

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Circumstances

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Dementia (with infarct)**intermittent (cardiac)**Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician2 ☐ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Howard B. Chen*

29c. License number

D 21680

29d. Date signed (Month, Day, Year)

July 21, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6717 Park Heights Avenue Baltimore

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

*Johanna R. Ricketts*

21215

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

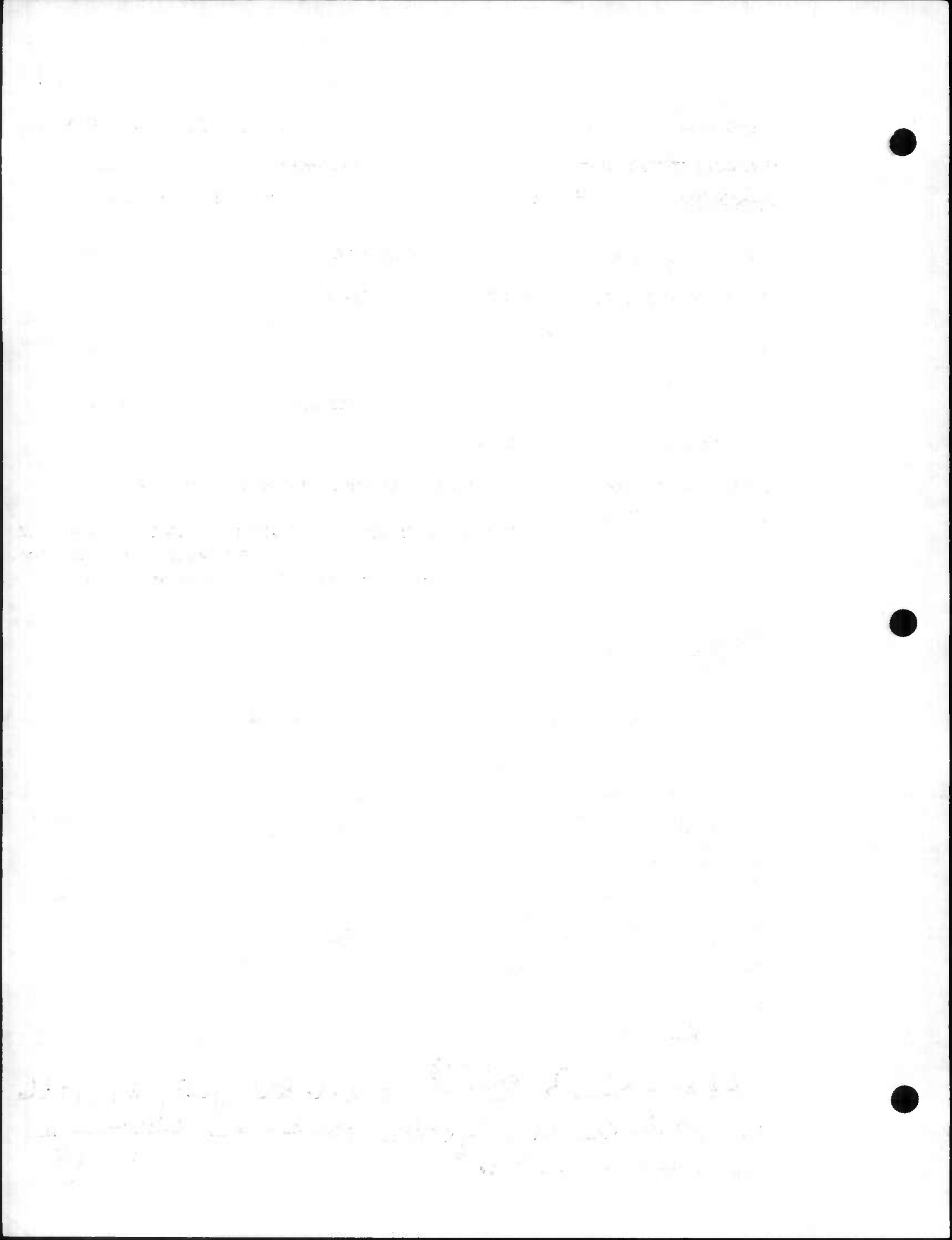
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21752

|  |  |   |  |   |  |  |  |   |
|--|--|---|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Edna E. Sturm                      |   |  |   | 2. Date of Death<br>Month Day Year<br>July 21 1996 |  | 3. Time of Death<br>3:45 p.m.  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>Stella Maris |   |  |   | 4b. City, Town, or Location of Death<br>Towson     |  | 4c. County of Death<br>Baltimore   |   |
| Funeral<br>Director  | 5. Social Security Number<br>212-03-8710                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>100 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth (Month, Day, Year)<br>May 1, 1896   |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |
|  | Usual Residence of Decedent  |   |  |   |  |  |  |   |
| 10a. State<br>Maryland   |  | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>Baltimore  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 10e. Street and Number<br>5404 Elstrode Avenue   |  |   |  | 10f. Zip Code<br>21214  |  | 10g. Citizen of What Country?<br>United States   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 Collega (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Seamstress   |  |  | 16b. Kind of Business/Industry<br>Clothing Company   |   |
| 17. Father's Name (First, Middle, Last)<br>Alfred Edwin Robinson   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Ann Marie Schuster   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Anna E. Galster/ Daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2502 Gibbons Avenue Baltimore, Maryland 21214  |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Memorial Gardens   |  | Date<br>7/25/96   |  | 20c. Location - City or Town, State<br>Timonium, Maryland  |  |   |
| 21. Signature of Funeral Service Licensee<br>Brian A. Willem   |  |   |  | 22. Name and Address of Facility<br>Leonard J. Ruck, Inc.<br>5305 Harford Road Baltimore, Maryland 21214  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Congestive Heart Failure<br>Dua to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>b. Dua to (or as a consequence of):<br><br>c. Dua to (or as a consequence of):<br><br>d. |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier   |  | 29c. License number<br>15564  |  | 29d. Date signed (Month, Day, Year)<br>7-22-96   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Eddie Nakhuda, M.D. 2300 Dulaney Valley Road, Towson, MD 21204   |  |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996   |  | 32. Registrar's Signature<br>John Burdon-Randall  |  |   |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the transparency and accountability of the organization. This section also outlines the various methods used to collect and analyze data, ensuring that the information is reliable and up-to-date.

2. The second part of the document focuses on the implementation of these practices. It provides a detailed overview of the systems and procedures in place to ensure that all data is properly recorded and maintained. This includes a discussion of the roles and responsibilities of the staff involved in the process, as well as the specific steps taken to ensure compliance with the relevant regulations.

3. The third part of the document addresses the challenges faced in the implementation of these practices. It identifies the key areas where difficulties have arisen and provides a detailed analysis of the reasons behind these challenges. This section also offers suggestions for how these challenges can be overcome, ensuring that the organization is able to maintain the highest standards of accuracy and transparency.

4. The fourth part of the document provides a summary of the findings and conclusions of the study. It highlights the key points made throughout the document and provides a clear overview of the overall results. This section also includes a discussion of the implications of the findings for the organization and the wider industry, as well as a final conclusion on the importance of maintaining accurate records of all transactions.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21753

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gilbert C. Schott

2. Date of Death  
Month Day Year

July 16, 1996

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

4264 Chapel Road

4b. City, Town, or Location of Death

Perry Hall

4c. County of Death

Baltimore

Funeral  
Director5. Social Security Number  
212-30-42016. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
62 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

August 23, 1933 Maryland

9. Birthplace (State or Foreign  
Country)

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

4264 Chapel Road

10f. Zip Code

21128

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Printing Company

17. Father's Name (First, Middle, Last)

Charles J. Schott

18. Mother's Name (First, Middle, Maiden Surname)

Emma Margaret Kahl

19a. Informant's Name/Relationship (Type, Print)

Mary Schott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4264 Chapel Road Perry Hall, Maryland 21128

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parkwood Cemetery

Date

7/19/1996 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Martin J. Dippel

22. Name and Address of Facility

The Dippel Funeral Home Inc.  
7110 Belair Road Baltimore, Maryland 2120623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Metastatic lung cancer  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

~ 2 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Paul Chang MD

29c. License number

D16587

29d. Date signed (Month, Day, Year)

7/16/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Chang, MD 5601 Loch Raven Blvd, Balto, MD 21239

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

Julia Davidson-Randall

State

Registrar

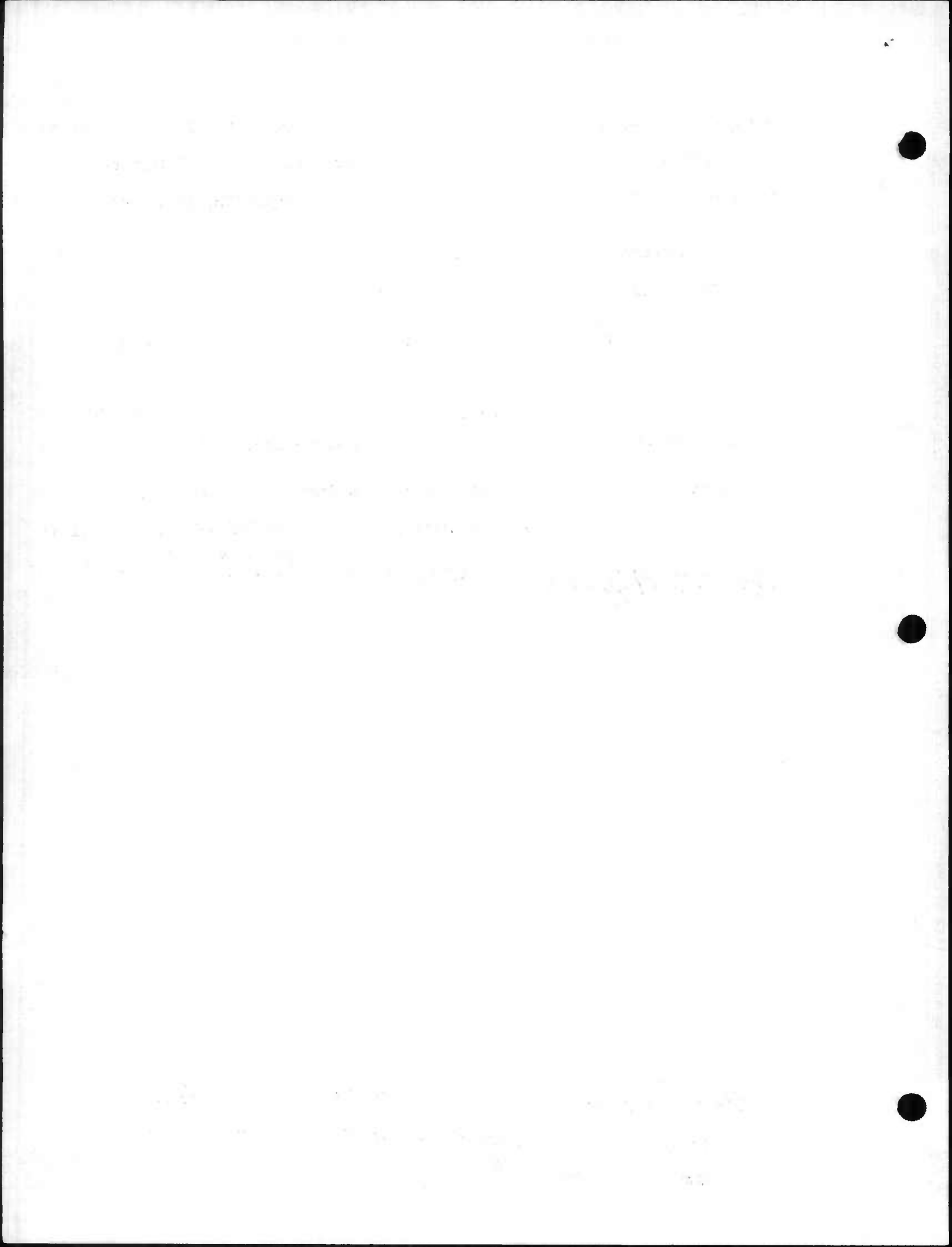
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21754

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Marie SMETANA</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>July 19, 1996</b>   |  | 3. Time of Death<br><b>4:20 am</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |  | 4c. County of Death<br><b>Baltimore County</b>  |  |
| 5. Social Security Number<br><b>216-36-9266</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 26, 1910</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore County</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>8425 Allison Lane</b>  |  | 10f. Zip Code<br><b>21237</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>William Charles Regan</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katherine M. Rain</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>C. Marlene Folio / Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8425 Allison Lane, Baltimore, Maryland 21237</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Redeemer Cemetery</b>  |  | 20c. Date<br><b>7/22/96</b>   |  | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br>   |  |
| 22. Name and Address of Facility<br><b>John C. Miller, Inc.<br/>6415 Belair Road, Baltimore, Maryland 21206</b>  |  | 23a. Part I. Enter the disease, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pneumonia</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | Approximate Interval Between Onset and Death<br><b>1 month</b>  |  |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Sacral Decubitus Ulcer</b>   |  | 23d. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 23e. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24. Dehydration   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  |
| 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>H 35593</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 19, 1996</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John Loh M.D. 1124 Mace Avenue Baltimore, MD 21221</b>  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  | 32. Registrar's Signature<br>   |  |   |  |

State  
Registrar

1. The first part of the paper is devoted to a general discussion of the problem of the existence of solutions of the system of equations

which are satisfied by the functions  $u_i(x, y, z)$  and  $v_i(x, y, z)$  in the domain  $D$  of the space  $E_3$ .

2. In the second part of the paper we shall consider the problem of the existence of solutions of the system of equations

which are satisfied by the functions  $u_i(x, y, z)$  and  $v_i(x, y, z)$  in the domain  $D$  of the space  $E_3$ .

3. In the third part of the paper we shall consider the problem of the existence of solutions of the system of equations

which are satisfied by the functions  $u_i(x, y, z)$  and  $v_i(x, y, z)$  in the domain  $D$  of the space  $E_3$ .

4. In the fourth part of the paper we shall consider the problem of the existence of solutions of the system of equations

which are satisfied by the functions  $u_i(x, y, z)$  and  $v_i(x, y, z)$  in the domain  $D$  of the space  $E_3$ .

5. In the fifth part of the paper we shall consider the problem of the existence of solutions of the system of equations

which are satisfied by the functions  $u_i(x, y, z)$  and  $v_i(x, y, z)$  in the domain  $D$  of the space  $E_3$ .

6. In the sixth part of the paper we shall consider the problem of the existence of solutions of the system of equations

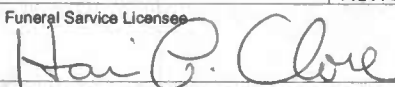
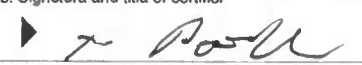
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21755

## Certificate of Death

Reg. No.

|   |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
|---|--|---|---|--|---|--|---|---|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>FRANKIE L. THOMAS</b>   |   |   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1996</b>      |   | 3. Time of Death<br><b>6:00 pm.</b>  |  |   |  |   |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>JOSEPH RITCHIE HOSPICE</b>  |   |   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>             |   | 4c. County of Death<br><b>N/A</b>  |  |   |  |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-50-2746</b>  |   | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.                                 | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 21 1949</b>                |   | 9. Birthplace (State or Foreign Country)<br><b>SOUTH CAROLINA</b>                              |  |   |  |   |  |  |
|   | Usual Residence of Decedent  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |   |  |  |
|   | 10e. Street and Number<br><b>5314 CARRIAGE COURT</b>   |   |   |  | 10f. Zip Code<br><b>21229</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                            |   |  |  |   |  |   |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |  |   |  |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th grade</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Asst. Accountant</b>  |  |   | 16b. Kind of Business/Industry<br><b>Baltimore Public School</b>        |  |  |   |  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Jerome Thomas</b>  |   |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Tyfenia Blair</b> |   |  |  |   |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eartha Session/ Sister</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5314 Carriage Court, Baltimore Maryland 21229</b>   |  |   |   |  |  |   |  |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>   |  | Date<br><b>7-24-96</b>  |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>         |   |  |  |   |  |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>WILLIAM C. BROWN COMMUNITY F/H<br/>1206 W. NORTH AVENUE</b>  |  |   |   |  |  |   |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Pneumonia and lung abscess</b><br/>Due to (or as a consequence of):</td> <td rowspan="4">Approximate interval Between Onset and Death<br/><b>4 months</b><br/><b>5 years</b></td> </tr> <tr> <td>b. <b>AIDS</b><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. <b>IV acquired sepsis</b><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table> |   |   |  |   |  |   |   |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Pneumonia and lung abscess</b><br>Due to (or as a consequence of): | Approximate interval Between Onset and Death<br><b>4 months</b><br><b>5 years</b> | b. <b>AIDS</b><br>Due to (or as a consequence of): | c. <b>IV acquired sepsis</b><br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Pneumonia and lung abscess</b><br>Due to (or as a consequence of):   | Approximate interval Between Onset and Death<br><b>4 months</b><br><b>5 years</b> |   |  |   |  |   |   |  |  |   |  |   |  |  |
|   | b. <b>AIDS</b><br>Due to (or as a consequence of):   |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
|   | c. <b>IV acquired sepsis</b><br>Due to (or as a consequence of):   |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
|   | d.   |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice Richey</b>   |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |   |   |  |  |   |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |  |   |  |   |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br> <b>M.D.</b>  |  |   |   | 29c. License number<br><b>D 13006</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>22 July 96</b>                     |   |   |  |  |   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas Powell, 101 W. Read St., Baltimore 21201</b>  |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |
| 32. Registrar's Signature<br>  |  |   |   |  |   |  |   |   |  |  |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

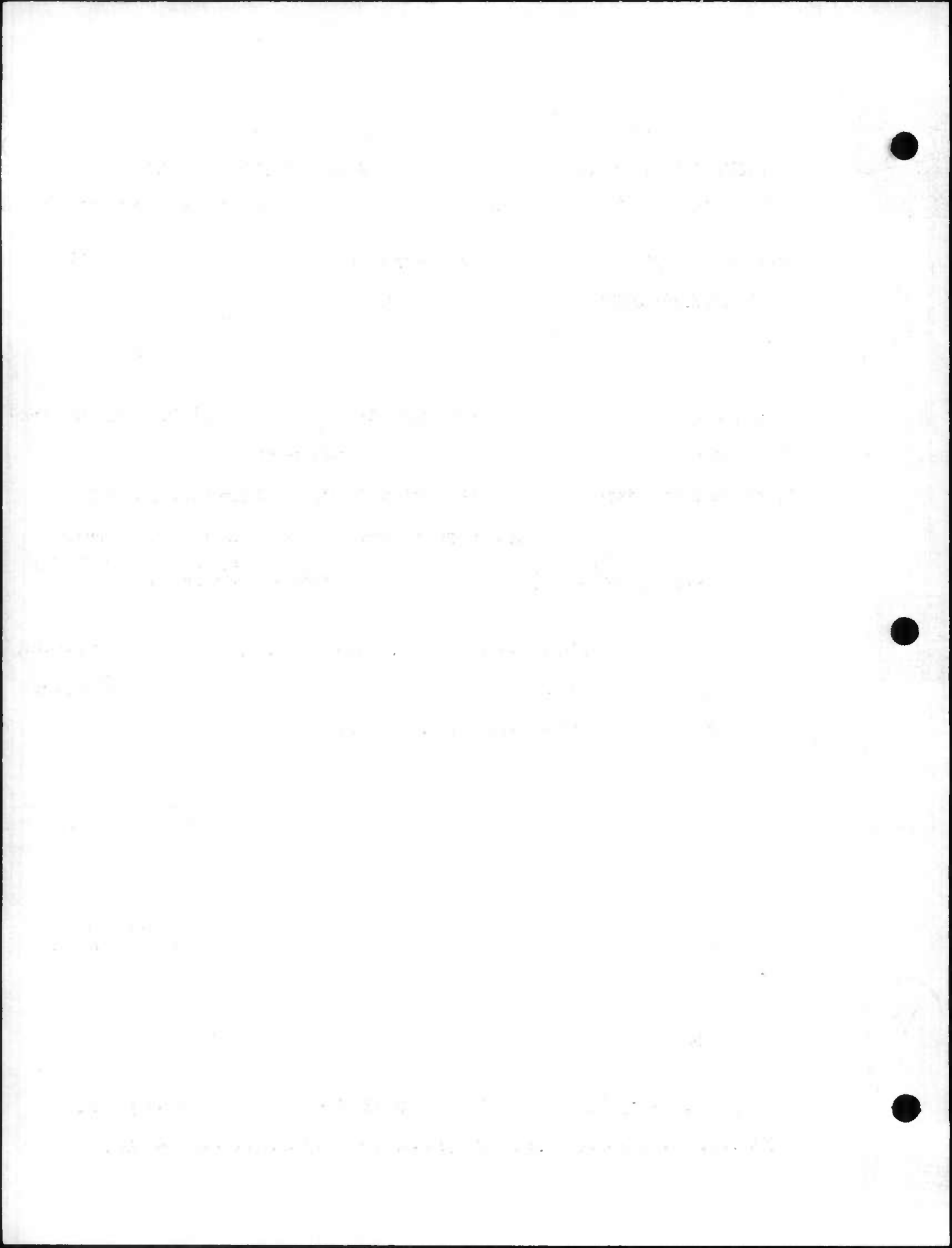
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



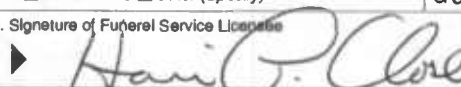
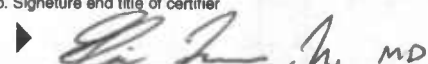
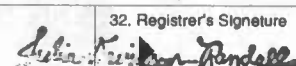
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21756

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |  |  |
|---|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH LEON THOMAS, SR.</b>   |   |   |   | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>1700</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-03-2056</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.      | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 20, 1918</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | 10a. State<br><b>Md.</b>   |   | 10b. County<br><b>Baltimore City</b>  |   | 10c. City, Town or Location<br><b>Baltimore City</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>4205 Flowerton Road</b>   |   |   |   | 10f. Zip Code<br><b>21229</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>                       |   | 16b. Kind of Business/Industry<br><b>Paper Company</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Melvin Thomas</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maggie Robinson</b>  |  |  |  |
| Physician<br>/Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>June Gaither/Daughter</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4205 Flowerton Road, Baltimore, Md. 21229</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>  |   | Date<br><b>7/25/96</b>   |  | 20c. Location - City or Town, State<br><b>Garrison, Md.</b>                                    |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>William C. Brown Community Funeral Home<br/>1206 W. North Ave. Baltimore, Md. 21217</b>                    |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. <b>CHRONIC LUNG DISEASE</b><br/>Due to (or as a consequence of):</p> <p>b. <b>ASCVD</b><br/>Due to (or as a consequence of):</p> <p>c. <b>CHRONIC RENAL FAILURE</b><br/>Due to (or as a consequence of):</p> <p>d. <b>METASTATIC TRANSITIONAL CELL CANCER</b><br/>Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p><b>YEARS</b></p> <p><b>YEARS</b></p> <p><b>YEARS (3)</b></p> <p><b>YEARS (6)</b></p> </div> </div> |   |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NONE</b>   |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>NA</b>   |   | 28b. Time of Injury<br><b>NA</b> M                    |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred<br><b>NA</b>   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>NA</b>   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>NA</b>  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br> MD   |   |   |  |  |  |  |
|   |  | 29c. License number<br><b>2522</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>7/12/96</b> |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>E.K. FRAZIER, JR. St. Agnes Hospital Dept of Surgery 900 CATON AVE Baltimore, MD 21229</b>   |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  | 32. Registrar's Signature<br>  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1-800-552-8888.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21757

|   |  |   |   |   |  |  |   |  |
|---|--|---|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Jack Troublefield</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>July 20, 1996</b>   |  | 3. Time of Death<br><b>11:05 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Corsica Hills Nursing Home</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Centreville</b>   |  | 4c. County of Death<br><b>Queen Annes</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-07-3643</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 12, 1914</b>                                     |   | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>  |
|   | Usual Residence of Decedent  |   |   |   |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>N/A</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>8702 Inwood Rd.</b>   |   |   | 10f. Zip Code<br><b>21244</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th Grade</b><br>College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self Employed</b>                 |   | 16b. Kind of Business/Industry<br><b>Ceramic Hardwood Floors</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Alfred Troublefield</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Martha Troublefield (Wife)</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8702 Inwood Rd. Baltimore, MD 21244</b> |  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>7-24-96 Baltimore, Maryland</b>  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Rd. Randallstown, MD 21133</b>                       |   |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Parkinson's</b><br>Due to (or as a consequence of):<br><b>b. Pneumonia</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |   | Approximate Interval Between Onset and Death<br><b>2 yr</b><br><b>1 week</b>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |  |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 28d. Describe how injury occurred  |  |   |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br><b>032036</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>7/22/96</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gary Sprouse, M.D.; 2108 Red Apple Plaza; Chester, Md. 21619</b>   |  |   |   |   |  |  |   |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |   | 32. Registrar's Signature<br>                                  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21758

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |   |
|--|---|---|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Sarah Jane Tann</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>July 18, 1996</b>   |  | 3. Time of Death<br><b>0345 AM</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Agnes Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>n/a</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>226-26-1487</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 14, 1996</b>                 | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b> |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>n/a</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
|  | 10e. Street and Number<br><b>804 North Augusta Avenue</b>   |   |   | 10f. Zip Code<br><b>21229</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>Black</b> |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>High School</b><br>College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b> |  | 16b. Kind of Business/Industry<br><b>U.S. Public Health</b>  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Major Robertson</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary J. Pear</b>   |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print) <b>Cousin</b><br><b>Janice W. Robertson</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5100 Kenilworth Avenue Baltimore, Maryland 21212</b>                                     |  |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>  |  | Data   | 20c. Location - City or Town, State<br><b>July 23 Baltimore County, MD</b>   |  |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Herbert E. Nutter</b>   |   |   |  | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</b>  |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Metastatic Lung Cancer</b><br>Due to (or as a consequence of):<br><br>b. <b>Diabetes</b><br>Due to (or as a consequence of):<br><br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br><br>d. <b>Coronary Artery Disease</b> |   |   |  |  |  |  |   |
|  | Approximate Interval Between Onset and Death<br><b>1 year</b><br><b>2 years</b><br><b>10 years</b><br><b>10 years</b>   |   |   |  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                                 |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>Allen Reilly MD</b>   |   |  |  |  |  |   |
|  |   | 29c. License number<br><b>P09138</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>July 18, 1996</b>  |  |  |  |   |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Allen Reilly, MD St. Agnes Hospital Center 900 Caton Ave. Balto, MD</b>   |   |   |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |   | 32. Registrar's Signature<br><b>Julia Anderson-Robertson</b>  |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



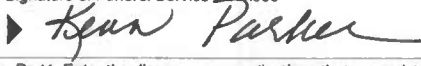
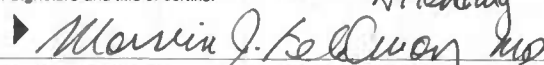
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21759

## Certificate of Death

Reg. No.

|   |  |                                       |   |  |   |   |  |   |
|---|--|---------------------------------------|---|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Richard Thornton, Sr.</b>   |                                       |   |  | 2. Date of Death<br>Month Day Year<br><b>July 16, 1996</b>  |   | 3. Time of Death<br><b>7:15PM</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Mercy Medical Center 301 St. Paul Place</b>   |                                       |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>n/a</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-24-2545</b>  |                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 11, 1930</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent  |                                       |   |  |   |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |                                       | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>3019 Gwynns Falls Parkway</b>   |                                       |   |  | 10f. Zip Code<br><b>21216</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assistant Principal</b>           |  |   |   | 16b. Kind of Business/Industry<br><b>Balto City Public Schls</b>                               |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Thornton</b>  |                                       |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Brown</b>   |   |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print) <b>wife</b><br><b>Shirley Thornton</b>  |                                       |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3019 Gwynns Falls Parkway Baltimore, MD 21216</b>   |   |  |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | Date<br><b>July 19</b>  |   | 20c. Location - City or Town, State<br><b>Catonsville, Maryland</b>                            |   |
|   | 21. Signature of Funeral Service Licensee<br>  |                                       |   |  | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</b>   |   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metabolic Acidosis</b><br>Due to (or as a consequence of):<br><b>b. Metastatic Carcinoma of the Lung</b><br>Due to (or as a consequence of):<br><b>c. </b><br>Due to (or as a consequence of):<br><b>d. </b> |                                       |   |  |   |   |  |   |
|   | Approximate Interval Between Onset and Death<br><b>3 days</b><br><b>1 year</b>   |                                       |   |  |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Cardomyopathy</b><br><b>Acute Renal Failure</b><br><b>Acute Hepatic Dysfunction</b>   |  |                                       |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                       |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br><b>M</b>                  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                       |   | 28d. Describe how Injury occurred                |   |   |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                                       |   |  |   |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                       |   |  |   |   |  |   |
| 29b. Signature and title of certifier<br><br><b>Attending</b>  |  |                                       |   | 29c. License number<br><b>D07930</b>             |   | 29d. Date signed (Month, Day, Year)<br><b>July 16, 1996</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Marvin J. Feldman, MD 301 St. Paul Place, Baltimore, MD 21202</b>  |  |                                       |   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  |                                       |   |  |   |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21760

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |   |   |  |   |  |   |  |  |
|---|--|---|--|--|--|--|---|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD H. THOMAS</b>                                 |   |  |  | 2. Date of Death<br>Month Day Year<br><b>July 14, 1996</b> |  | 3. Time of Death<br><b>4:50 p.m.</b>                              |   |  |   |  |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  | 4c. County of Death<br><b>Frederick</b>                           |   |  |   |  |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>148-26-5330</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                             | 8. Date of Birth (Month, Day, Year)<br><b>May 14, 1934</b>   | 9. Birthplace (State or Foreign Country)<br><b>Wilmington, DE</b> |   |  |   |  |   |  |  |
|   | Usual Residence of Decedent  |   |  |  |  |  |   |   |  |   |  |   |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |   |  |  |
| 10e. Street end Number<br><b>5704 Trail View Ct.</b>  |  |   |  | 10f. Zip Code<br><b>21703</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |  |   |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korea</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |   |  |   |  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Topographer</b>  |  | 16b. Kind of Business/Industry<br><b>Dept. of Defense</b>  |   |   |  |   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Harpel Thomas</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Olivia Stanert</b>  |  |  |   |   |  |   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathy Ranson</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7075 Bradshaw Ct., Frederick, MD 21703</b>   |  |  |   |   |  |   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chestnut Grove Cemetery</b>  |  | Data<br><b>7/18/96</b>   |  | 20c. Location - City or Town, State<br><b>Herndon, VA</b>  |   |   |  |   |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>J. Buckley</b>  |  |   |  | 22. Name and Address of Facility<br><b>Green Funeral Home, Inc.<br/>721 Elden St., Herndon, VA 20172</b>   |  |  |   |   |  |   |  |   |  |  |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |   |   |  |   |  |   |  |  |
| <table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Sepsis</b><br/>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>hours</b><br/><br/><b>~ 3 months</b></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>Lung Cancer</b><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____<br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____<br/>Due to (or as a consequence of):</td> </tr> </table> |  |   |  |  |  |  |   | Immediate Cause (Final disease or condition resulting in death) | a. <b>Sepsis</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><b>hours</b><br><br><b>~ 3 months</b> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <b>Lung Cancer</b><br>Due to (or as a consequence of): | c. _____<br>Due to (or as a consequence of): | d. _____<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Sepsis</b><br>Due to (or as a consequence of):   | Approximate Interval Between Onset and Death<br><b>hours</b><br><br><b>~ 3 months</b>   |  |  |  |  |   |   |  |   |  |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. <b>Lung Cancer</b><br>Due to (or as a consequence of):  |   |  |  |  |  |   |   |  |   |  |   |  |  |
|   | c. _____<br>Due to (or as a consequence of):   |   |  |  |  |  |   |   |  |   |  |   |  |  |
|   | d. _____<br>Due to (or as a consequence of):   |   |  |  |  |  |   |   |  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |   |  |   |  |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  |   |  |  |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |  |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |   |  |   |  |  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |   |   |  |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>Lloyd Halverson MD</b>  |  | 29c. License number<br><b>D 22101</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/14/96</b>  |   |   |  |   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Lloyd Halverson MD, 1475 Tany Ave. Frederick MD 21701</b>  |  |   |  |  |  |  |   |   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>   |  |   |  |  |  |  |   |   |  |   |  |   |  |  |
| 32. Registrar's Signature<br><b>Julia Davidson</b>  |  |   |  |  |  |  |   |   |  |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicians: The law requires that the death certificate be executed within 24 hours of death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21761

|   |  |  |   |  |  |  |  |  |   |                             |  |                                     |          |
|---|--|--|---|--|--|--|--|--|---|-----------------------------|--|-------------------------------------|----------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Kenneth Edgar WIDERMAN   |  |   |  | 2. Date of Death<br>Month: Jul. Day: 19, Year: 1996  |  | 3. Time of Death<br>7:41 PM                                      |  |   |                             |  |                                     |          |
|   | 4e. Facility Name (If not institution, give street and number)<br>4416 ELDONE ROAD   |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>N/A                                       |  |   |                             |  |                                     |          |
| Funeral<br>Director   | 5. Social Security Number<br>219-22-0539   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>68 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>JAN 3, 1928               |  |   |                             |  |                                     |          |
|   | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  | 10a. State<br>MD  |  | 10b. County<br>N/A   |  | 10c. City, Town or Location<br>BALTIMORE                         |  |   |                             |  |                                     |          |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |   |                             |  |                                     |          |
|   | 10e. Street and Number<br>4416 ELDONE ROAD   |  |   |  | 10f. Zip Code<br>21229   |  | 10g. Citizen of What Country?<br>U.S.A.                          |  |   |                             |  |                                     |          |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |  |   |                             |  |                                     |          |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SUPERVISOR CUSTOMER SER                    |  | 16b. Kind of Business/Industry<br>BALTO GAS & ELECTRIC   |  |  |  |   |                             |  |                                     |          |
|   | 17. Father's Name (First, Middle, Last)<br>RAYMOND EDGAR WIDERMAN  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY ELLEN LEWIS  |  |  |  |   |                             |  |                                     |          |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>VIRGINIA L. WIDERMAN (WIFE)  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4416 ELDONE ROAD - BALTIMORE, MD 21229  |  |  |  |   |                             |  |                                     |          |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>LORRAINE PARK CEMETERY  |  | 20c. Date<br>7/23/96   |  | 20d. Location - City or Town, State<br>BALTIMORE                 |  |   |                             |  |                                     |          |
|   | 21. Signature of Funeral Service Licensee<br><i>M. Neal Coleman</i>  |  |   |  | 22. Name and Address of Facility<br>HUBBARD FUNERAL HOME, INC.<br>4107 WILKENS AVENUE-BALTIMORE, MD 21229  |  |  |  |   |                             |  |                                     |          |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |   |                             |  |                                     |          |
|   | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Due to (or as a consequence of):<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <i>Cerebral Aneurysm</i></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <i>Compensated heart failure</i></td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. _____</td> </tr> </table> |  |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <i>Cerebral Aneurysm</i> | Approximate Interval Between Onset and Death | b. <i>Compensated heart failure</i> | c. _____ |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a. <i>Cerebral Aneurysm</i>  | Approximate Interval Between Onset and Death   |   |  |  |  |  |  |   |                             |  |                                     |          |
|   | b. <i>Compensated heart failure</i>  |  |   |  |  |  |  |  |   |                             |  |                                     |          |
|   | c. _____   |  |   |  |  |  |  |  |   |                             |  |                                     |          |
|   | d. _____   |  |   |  |  |  |  |  |   |                             |  |                                     |          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |                             |  |                                     |          |
|   |  |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |                             |  |                                     |          |
|   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |                             |  |                                     |          |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |   |                             |  |                                     |          |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |                             |  |                                     |          |
|   |  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |                             |  |                                     |          |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |  |  |  |   |                             |  |                                     |          |
| 29b. Signature and title of certifier<br><i>Stephen J. Plantinga MD</i>   |  |  |   | 29c. License number<br>D 23580   |  | 29d. Date signed (Month, Day, Year)<br>Jul 20, 1996  |  |  |   |                             |  |                                     |          |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>STEPHEN PLANTINGA   |  |  |   |  |  |  |  |  |   |                             |  |                                     |          |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996  |  | 32. Registrar's Signature<br><i>John [Signature]</i>   |   |  |  |  |  |  |   |                             |  |                                     |          |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21762

|   |   |  |  |  |   |  |  |  |
|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Geneva A. Warner                              |  |  |  | 2. Date of Death<br>Month Day Year<br>07-19-1996  |  | 3. Time of Death<br>9:45p.m.                         |  |
|   | 4a. Facility Name (if not institution, give street and number)<br>723 South Oldham Street |  |  |  | 4b. City, Town, or Location of Death<br>Baltimore |  | 4c. County of Death<br>N/A -                         |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-46-5760  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (in yrs. last birthday)<br>81 Yrs.         |  | 8. Date of Birth (Month, Day, Year)<br>July 17, 1915 |  |
|   | 9. Birthplace (State or Foreign Country)<br>Md  |  | 10a. State<br>Md   |  | 10b. County<br>N/A                                |  | 10c. City, Town or Location<br>Baltimore             |  |
| Usual Residence of Decedent   |   |  |  |  |   |  |  |  |
| 10a. State<br>Md  |   |  | 10b. County<br>N/A   |  |   | 10c. City, Town or Location<br>Baltimore   |  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  | 10e. Street and Number<br>723 S. Oldham Street   |  |   | 10f. Zip Code<br>21224   |  |  |
| 10g. Citizen of What Country?<br>USA  |   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |   |  | 16b. Kind of Business/Industry<br>Own Home   |  |   | 17. Father's Name (First, Middle, Last)<br>Emmanuel Smith  |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br>Katherine Ortel  |   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Audrey Warner/Daughter   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>723 S. Oldham St. Balto, Md. 21224  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Oaklawn Cemetery   |  |   | 20c. Location - City or Town, State<br>Baltimore, Md   |  |  |
| 21. Signature of Funeral Service Licensee<br>Peter S. Ashton  |   |  | 22. Name and Address of Facility<br>Moran Ashton Funeral Home<br>3000 E. Baltimore St., Balto, Md. 21224   |  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Pancreatic Cancer |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>n/a   |   |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                  |   |  | 28a. Date of Injury (Month, Day Year)  |  |   | 28b. Time of Injury<br>M   |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  | 28d. Describe how injury occurred  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   | 29b. Signature and title of certifier<br>D. MacDonald  |  |  |
| 29c. License number<br>DIS-408  |   |  | 29d. Date signed (Month, Day, Year)<br>7/20/96   |  |   | 30. Name and address of person who completed cause of death (Item 28c) (Type, Print)<br>D. MacDonald 9 S. Highland Ave 21224   |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996  |   |  | 32. Registrar's Signature<br>G. Davidson-Randall   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

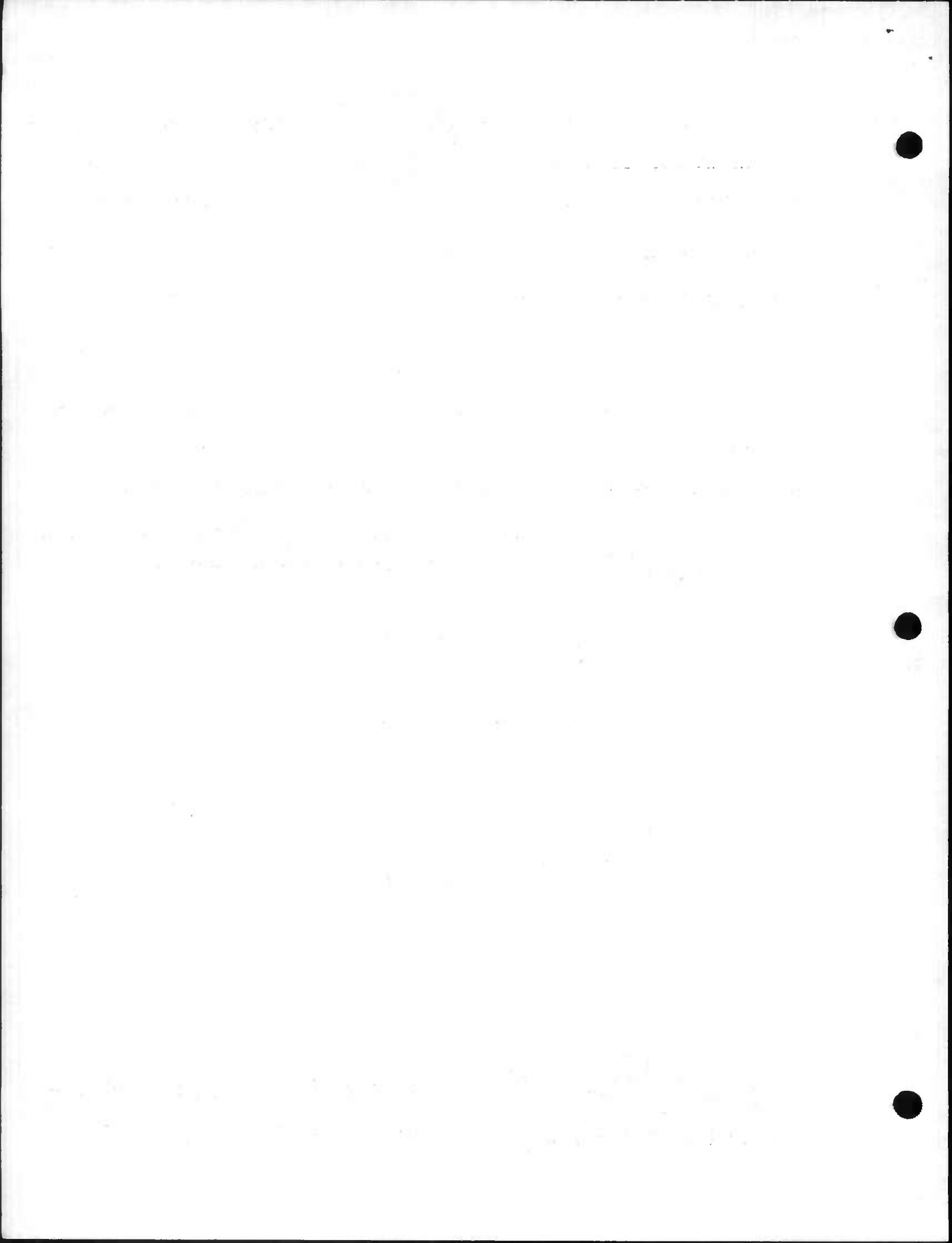


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **96 21763**  
Certificate of Death

Reg. No.

|   |  |  |   |                                |   |  |   |  |
|---|--|--|---|--------------------------------|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Rose M. Willette</b>  |  |   |                                | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>4:14 PM</b>  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Northwest Hospital Center</b>   |  |   |                                | 4b. City, Town, or Location of Death<br><b>Randallstown</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-26-3654</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Mar 19, 1913</b>                                     |   | 9. Birthplace (State or Foreign Country)<br><b>Puerto Rico</b> |
|   | Usual Residence of Decedent  |  |   |                                |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>N/A</b>   |                                |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>3522 Langrehr Road Apt. 1A</b>  |  |   |                                | 10f. Zip Code<br><b>21244</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Civil Service</b>                 |                                |   | 16b. Kind of Business/Industry<br><b>Army Personnel Dept.</b>                                  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Ernest Barbosa Son</b>  |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8349 Mindale Circle Baltimore, MD 21244</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lake View Mem. Park</b>  |                                | Date<br><b>7/22/96</b>  |  | 20c. Location - City or Town, State<br><b>Sykesville, Maryland</b>                          |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |                                | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD 21133</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute renal failure</b><br>Due to (or as a consequence of):<br><b>b. Congestive heart failure</b><br>Due to (or as a consequence of):<br><b>c. Chronic cardiomyopathy</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |                                |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |                                |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |                                |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |                                |   |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Hypothyroidism</b><br><b>Left Cerebrovascular Accident</b>   |  |   |                                |   |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |                                | 28d. Describe how injury occurred   |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |                                |   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                |   |  |   |  |
|   | 29b. Signature and title of certifier<br><br><b>M.D.</b>   |  | 29c. License number<br><b>D-48171</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>July 21st 1996</b>  |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Perwaiz H. Rahim - Northwest Hosp. Center</b>   |  |   |                                |   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1996</b>  |  |   |                                |   |  |   |  |



96 21764

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Borst Weber</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 21, 1996</b>  |  |  |  | 3. TIME OF DEATH<br><b>2:15pm</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>195-22-1938</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 14, 1928</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>PA</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>23 Derwood Court</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Parkville</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Parkville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>23 Derwood Court</b>   |  |  |  | 10f. ZIP CODE<br><b>21234</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br><b>47-51</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Police Officer</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Balto. Co.</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Weber</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ethel Borst</b>   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret Weber</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23 Derwood Court Baltimore Md. 21234</b>  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery 7/24/96</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. Terry Connelly</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer lung</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>1 year</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M t                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
|   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D18487</b>  |  |  |  | 29d. DATE SIGNED (Month/Day/Year)<br><b>7/22/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MYO THANT 9101 FRANKLIN SQUARE DR., BALTO, MD 21237</b>   |  |  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 23 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 38760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21765

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONALD JOSEPH WALTMAN

2. Date of Death

Month Day Year  
JULY 17 1996

3. Time of Death

3:30 PM

4a. Facility Name (If not institution, give street and number)

712 MAYO ROAD

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

217-26-7217

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11/18/1916

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

712 MAYO ROAD

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1936-1961

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4or 5+)

12 NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SOLDIER

16b. Kind of Business/Industry

UNITED STATES ARMY

17. Father's Name (First, Middle, Last)

JOSEPH W. WALTMAN

18. Mother's Name (First, Middle, Maiden Surname)

JENNIE MAY WATSON

19a. Informant's Name/Relationship (Type, Print)

JOHN E. WALTMAN (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 F. LENLOW CT., GLEN BURNIE, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK

Date

7/22/96

20c. Location - City or Town, State

ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME

1 SECOND AVE. S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Prostate Cancer with metastasis 3 yrs.

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension  
Acromegaly

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Salvacion A. Dupaya

29c. License number

D38912

29d. Date signed (Month, Day, Year)

07/18/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SALVACION A. Dupaya M.D.

1720 Crain Highway Suite 204 Glen Burnie MD 21061

31. Date filed (Month, Day, Year)

JUL 23 1996

Registrar's Signature

John E. Waltman

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached and filed as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21766

|   |   |  |   |  |  |   |  |  |
|---|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>BEATRICE M. YEATON  |  |   |  | 2. Date of Death<br>Month Day Year<br>JULY 18 1996   |   | 3. Time of Death<br>2:05am   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>3207 STAFFORD STREET  |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |   | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-09-7038  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>85 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>JULY 8, 1911  |  |
|   | 9. Birthplace (State or Foreign Country)<br>MARYLAND  |  | 10a. State<br>MD  |  | 10b. County<br>N/A   |   | 10c. City, Town or Location<br>BALTIMORE   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>3207 STAFFORD STREET  |  | 10f. Zip Code<br>21229   |   | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12TH GRADE  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SWITCHBOARD OPERATOR   |  | 16b. Kind of Business/Industry<br>FUEL DELIVERY  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>UNKNOWN DEALE  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MELVA EBAUGH   |  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>RONALD YEATON (SON)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3207 STAFFORD STREET - BALTIMORE, MD 21229   |  |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>WESTERN CEMETERY  |  | Data<br>7/22/96  |   | 20c. Location - City or Town, State<br>BALTIMORE   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Hancy J. Thompson</i>   |  | 22. Name and Address of Facility<br>HUBBARD FUNERAL HOME INC.<br>4107 WILKENS AVENUE-BALTIMORE, MD 21229  |  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <u>Arteriosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>b. _____ Due to (or as a consequence of):<br><br>c. _____ Due to (or as a consequence of):<br><br>d. _____ |  |   |  |  |   | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|   |   |  |   |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   |   |  | 28d. Describe how injury occurred   |  |  |   |  |  |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br>O.C.M.E.  |   | 29d. Date signed (Month, Day, Year)<br>JULY 18, 1996   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David R Fowler 111 Penn Street, Baltimore, Maryland 21201 |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1996  |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i> |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21767

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward W. Young

2. Date of Death

Month Day Year  
July 18 1996

3. Time of Death

8:49 AM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

247-01-0674

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct 18, 1901

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3818 Woodridge Road

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

City of Balto Housing Authority

17. Father's Name (First, Middle, Last)

George Young

18. Mother's Name (First, Middle, Maiden Summa)

Cora Workman

19a. Informant's Name/Relationship (Type, Print)

Betty Dinton - Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3818 Woodridge Road Baltimore, Md 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Pl

Date

7/24/96

20c. Location - City or Town, State

Rundallstown, Md

21. Signature of Funeral Service Licensee

Sala March

22. Name and Address of Facility

March F.H. West  
4300 Walbrook Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence of):

b. Hyperkalemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

Myocardial Infarction

Colon Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

SK Schenck

29c. License number

89264

29d. Date signed (Month, Day, Year)

July 18, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Schwartz, M.D. c/o Maryland General Hospital

31. Date filed (Month, Day, Year)

JUL 23 1996

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a is marked "any injury or other traumatic event, the Medical Examiner must be notified in person."

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 21768

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Pearl Estelle Zang</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>July</b> DAY <b>22</b> YEAR <b>1996</b>  |  |   |  | 3. TIME OF DEATH<br><b>10:17am</b>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-30-6218</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                        |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Mar. 4, 1908</b>                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Annapolis Nursing &amp; Rehab.Ctr.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Annapolis</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br><b>4 Wallington Place</b>   |  |  |  | 10f. ZIP CODE<br><b>21403</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sales Clerk</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Retail</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William L. Norwood</b>  |  |  |  |   |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Etta Brooks</b> |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret Rogers</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1132 Cove Road, Apt. 202, Annapolis, MD 21403</b>   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Quaker Cemetery</b>   |  |   |  | DATE<br><b>7/24</b>   |  | 20c. LOCATION — City or Town, State<br><b>Galesville, MD</b>    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas Handstey</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multi-System Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>3 months</b> |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED                               |  |
|   |  |  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. I. Hochman, MD</i>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>DO5192</b>                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/22/96</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. I. Hochman, MD - 1833 A Forest Drive, Annapolis, MD 21401</b>  |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 23 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>W. Handstey</i>   |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 7, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21769

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |   |   |   |  |
|---|--|--|---|---|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EDWARD ANTHONY ARNOLD</b>   |  |   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 13 1996</b>                                   |   | 3. Time of Death<br><b>8:47 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>  |  |   |   |  |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>                                       |   | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>N/A</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>N/A</b> 0 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>18 JULY 13, 1996</b> |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |   |  |
|   | Usual Residence of Decedent  |  |   |   |  |  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Harford County</b>                                       |   | 10c. City, Town or Location<br><b>Edgewood</b>  |  |  | 10d. Inside City Limits   |   |   |  |
|   | 10e. Street and Number<br><b>818 Olive Court</b>   |  |   | 10f. Zip Code<br><b>21041</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                 |   |   |   |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b> |  |  | 16b. Kind of Business/Industry<br><b>N/A</b>  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>EDWARD ARNOLD</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CLARA ANN O'ONFRIO ARNOLD</b>  |  |   |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Father Edward Edmund Arnold, Jr.</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>818 Olive Court, Edgewood, Maryland 21041</b>  |  |   |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |   |   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Katherine M. Murphy</b>  |  |   |   | 22. Name and Address of Facility<br><b>John C. Miller, Inc.<br/>6415 Belair Road, Baltimore, Maryland 21206</b>  |  |   |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>EXTREME PREMATURELY</b><br>Due to (or as a consequence of):<br><b>PRE-TERM LABOR</b> |  |   |   |  |  |   |   |   | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred   |  |
|   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |  |   |   |   |  |
| 29b. Signature and title of certifier<br><b>Virma V. Torres, MD</b>   |  |  |   | 29c. License number<br><b>D20269</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 14, 1996</b>                                 |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>VIRMA V. TORRES MD</b>   |  |  |   |   |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |  |  | 32. Registrar's Signature<br><b>John Andrew Randall</b>   |   |  |  |   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21770

Reg. No.

|  |   |                                      |   |   |   |   |  |
|--|---|--------------------------------------|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>AMANDA GRACE ARNOLD</b>  |                                      |   | 2. Date of Death<br>Month Day Year<br><b>JULY 13 1996</b>   |   | 3. Time of Death<br><b>7:30 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |                                      |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |   | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>N/A</b>   |                                      | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>25 MIV 0</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>25 JULY 13, 1996</b>                       |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |                                      |   |   |   |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |                                      |   |   |   |   |  |
|  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Harford County</b> | 10c. City, Town or Location<br><b>Edgewood</b>  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  | 10e. Street and Number<br><b>818 Olive Court</b>  |                                      | 10f. Zip Code<br><b>21041</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>  |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>   |   | 16b. Kind of Business/Industry<br><b>N/A</b>  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>EDWARD ARNOLD</b>   |                                      |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CLARA ANN D'Onofrio ARNOLD</b>  |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Father Edward Edmund Arnold, Jr.</b>   |                                      |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>818 Olive Court, Edgewood, Maryland 21041</b> |   |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Katherine M. Murphy</b>   |                                      | 22. Name and Address of Facility<br><b>John C. Miller, Inc.<br/>6415 Belair Road, Baltimore, Maryland 21206</b>   |   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. EXTREME PREMATURITY</b><br>Due to (or as a consequence of):<br><b>b. PRE-TERM LABOR</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                      |   |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.         |   |                                      |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |   |                                      |   |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|  |   |                                      |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                      | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |                                      | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  |   |                                      | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred   |   |  |
|  |   |                                      |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
|  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |                                      |   |   |   |   |  |
| 29b. Signature and title of certifier<br><b>Virma V. Torres, MD</b>  |   | 29c. License number<br><b>D20269</b> |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 14, 1996</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>VIRMA V. TORRES, MD</b> <b>GBME</b> |   |                                      |   |   |   |   |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |                                      | 32. Registrar's Signature<br><b>John A. Russell</b>   |   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21771

## Certificate of Death

Reg. No.

|  |   |  |   |   |   |                                |  |   |
|--|---|--|---|---|---|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>ANNA MARIE ARNOLD</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>JULY 13 1996</b>   |                                | 3. Time of Death<br><b>8:50 PM</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |                                | 4c. County of Death<br><b>BALTIMORE</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>N/A</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>N/A 0</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>July 13, 1996</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|  | Usual Residence of Decedent   |  |   |   |   |                                |  |   |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Harford County</b>  |   | 10c. City, Town or Location<br><b>Edgewood</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>818 Olive Court</b>  |  |   |   | 10f. Zip Code<br><b>21041</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>   |                                | 16b. Kind of Business/Industry<br><b>N/A</b>   |   |
|  | 17. Father's Name (First, Middle, Last) <b>Edward Edmund Arnold Jr.</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname) <b>Glenn Arnold</b>   |                                |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print) <b>Father Edward Edmund Arnold, Jr.</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>818 Olive Court, Edgewood, Maryland 21041</b>   |                                |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery</b>   |                                | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                              |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Kathleen M. Murphy</b>  |  |   |   | 22. Name and Address of Facility<br><b>John C. Miller, Inc.<br/>6415 Belair Road, Baltimore, Maryland 21206</b>   |                                |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>EXTREME PREMATURITY</b><br>Due to (or as a consequence of):<br><b>PRE-TERM LABOR</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |   |   |                                |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |                                |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|  | 28d. Describe how Injury occurred   |  |   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |   |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |                                |  |   |
|  | 29b. Signature and title of certifier<br><b>Verma J. Torres MD</b>  |  |   |   | 29c. License number<br><b>D20269</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>JULY 14, 1996</b>                                    |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>VERMA J. TORRES MD</b>   |  |   |   |   |                                |  |   |
|  | 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |  |   |   | 32. Registrar's Signature<br><b>GRACE</b>   |                                |  |   |
|  | 33. State Registrar   |  |   |   |   |                                |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21772

## Certificate of Death

Reg. No.

|  |   |   |   |   |  |  |   |   |  |
|--|---|---|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><u>Kenneth Wilber Bagwell</u>   |   |   |   | 2. Date of Death<br>Month <u>July</u> Day <u>19</u> Year <u>1996</u>   |  | 3. Time of Death<br><u>11:42 AM</u>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>John Hopkins Bayview Medical Center</u>  |   |   |   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |  | 4c. County of Death<br><u>N/A</u>   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>213-64-8661</u>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><u>42</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>Oct. 1, 1953</u>  |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>   |   | 10a. State<br><u>Maryland</u>   |   | 10b. County<br><u>Baltimore</u>  |  | 10c. City, Town or Location<br><u>Dundalk</u>   |   |  |
| To Be Completed by Funeral Director                                  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><u>7832 St. Fabian Lane</u>   |   | 10f. Zip Code<br><u>21222</u>  |  | 10g. Citizen of What Country?<br><u>United States</u>   |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>Vietnam</u>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>   |   |  |
| To Be Completed by Physician/Medical Examiner                        | 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u><br><u>12 years</u>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Heavy Equipment Operator</u>  |   | 16b. Kind of Business/Industry<br><u>Construction</u>  |  | 17. Father's Name (First, Middle, Last)<br><u>Maurice Bagwell</u>   |   |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Mary (unknown)</u>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><u>Susan L. Bagwell</u>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7832 St. Fabian Lane Baltimore, Maryland 21222</u>                                       |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  |
| To Be Completed by Physician/Medical Examiner                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Holy Rosary Cemetery</u>   |   | 20c. Date<br><u>7/23/96</u>   |   | 20d. Location - City or Town, State<br><u>Dundalk, Maryland</u>  |  | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>   |   |  |
|  | 22. Name and Address of Facility<br><u>Duda-Ruck Funeral Home of Dundalk, Inc.</u><br><u>7922 Wise Avenue Dundalk, Maryland 21222</u>   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. Non-small cell lung cancer</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><u>b. _____</u><br>Due to (or as a consequence of):<br><br><u>c. _____</u><br>Due to (or as a consequence of):<br><br><u>d. _____</u> |   | Approximate interval between Onset and Death<br><u>2 mo</u>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| State Registrar  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |
|  | 29b. Signature and title of certifier<br><u>Paul V. O'Donnell MD PhD</u>  |   | 29c. License number<br><u>D47312</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>JULY 22, 1996</u>  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>PAUL V. O'DONNELL MD PhD, JOHNS HOPKINS ONCOLOGY CENTER, BALTIMORE MD 21287</u>  |   |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 24 1996</u>              |   | 32. Registrar's Signature<br><u>[Signature]</u> |   | 33. Registrar's Title<br><u>[Signature]</u> |  | 34. Registrar's Name<br><u>[Signature]</u> |   | 35. Registrar's Address<br><u>[Signature]</u> |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 21773

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Baker</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>June</b> DAY <b>26</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>1:25 p.m.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>427-462909</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br><b>65</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 22 1930</b>                                      |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Evergreen Nursing + Rehab Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>NA</b>  |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>NA</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>2525 W. Belvedere Ave</b>  |  |   |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korean War</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th</b> College (1-4 or 5+) <b></b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Truck Driver</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>UNKNOWN</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN HENRY BAKER, Sr</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Teresa Baker</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ELAINE BAKER</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1733 Orleans Street BALTO. MD. 21231</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory or other place)<br><b>Garrison Forest Veteran 7/5/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, MD</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>St. E. Howell</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>UNITY Funeral Home 21201<br/>108 W. NORTH AVENUE BALTO. MD</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiac arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <b>aspiration pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. <b>cerebrovascular accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Louis W. Miller</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>602421</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7-2-96</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Louis W. Miller 2525 W. Belvedere 21215</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 24 1996</b>   |  |   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





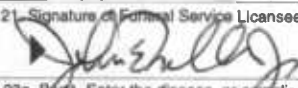
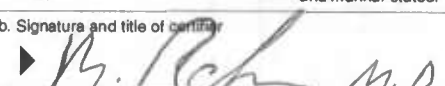
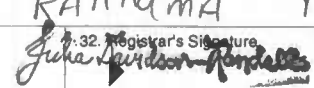
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 21774

Reg. No.

|  |   |                                 |   |   |  |  |   |  |   |  |
|--|---|---------------------------------|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Franklin Bascom</b>                            |                                 |   |   | 2. Date of Death<br>Month <b>July</b> , Day <b>20</b> , Year <b>1996</b>   |  |   |  | 3. Time of Death<br><b>10:00AM</b>                              |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6515 Eastbourne Ave.</b> |                                 |   |   | 4b. City, Town, or Location of Death<br><b>Dundalk</b>   |  |   |  | 4c. County of Death<br><b>Baltimore</b>                         |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>171-05-6269</b>   |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 28, 1912</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |  |
|  | Usual Residence of Decedent   |                                 |   |   |  |  |   |  |   |  |
| 10a. State<br><b>Md.</b>   |   | 10b. County<br><b>Baltimore</b> |   | 10c. City, Town or Location<br><b>Dundalk</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>6515 Eastbourne Ave.</b>  |   |                                 |   | 10f. Zip Code<br><b>21222</b>   |  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b>  |   |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Personel</b>  |  | 16b. Kind of Business/Industry<br><b>State Employed</b>                        |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Franflin Bascom</b>  |   |                                 |   |   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Mary Ella Broughton</b> |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William Bascom son</b>  |   |                                 |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23 Blue Rock Rd. Lenhartsville, Pa. 19534</b>   |  |  |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                                 |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | Date<br><b>7-24</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore</b>  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                                 |   | 22. Name and Address of Facility<br><b>Connelly Funeral Home Of Dundalk<br/>7110 Sollers Point Rd. 21222</b>  |  |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |                                 |   |   |  |  |   |  |   |  |
| Immediate Cause (Final disease or condition resulting in death)  |   |                                 |   | a. <b>Metastatic Cancer of Unknown Etiology</b>   |  |  |   | Approximate Interval Between Onset and Death<br><b>6 mos.</b>  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   |   |                                 |   | b. <b>NORMAL Pressure Hydrocephalus</b>   |  |  |   | Due to (or as a consequence of):<br><b>2 years</b>   |   |  |
|  |   |                                 |   | c. _____  |  |  |   | Due to (or as a consequence of):   |   |  |
|  |   |                                 |   | d. _____  |  |  |   | Due to (or as a consequence of):   |   |  |
|  |   |                                 |   | e. _____  |  |  |   | Due to (or as a consequence of):   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                 |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |   |                                 |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |   |                                 |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                 |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |                                 |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|  |   |                                 |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28d. Describe how Injury occurred  |   |  |
|  |   |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                                 |   | 29b. Signature and title of certifier<br>  |  |  |   | 29c. License number<br><b>D 45475</b>  |   |  |
|  |   |                                 |   | 29d. Date signed (Month, Day, Year)<br><b>7-22-96</b>   |  |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MOHAMMED RAHNUMA M.D. 19 Fontana Lane Suite 102 BALTO. MD 21232</b>   |   |                                 |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |   |                                 |   | 32. Registrar's Signature<br>  |  |  |   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21236-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21775

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |   |
|---|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>John Beckwith</u>  |  |  | 2. Date of Death<br>Month <u>July</u> Day <u>19</u> Year <u>1996</u>         |  | 3. Time of Death<br><u>8:30 a.m.</u>   |   |
|   | 4e. Facility Name (If not institution, give street and number)<br><u>JOSEPH RITCHIE HOSPICE</u>   |  |  | 4b. City, Town, or Location of Death<br><u>BALTIMORE</u>                     |  | 4c. County of Death<br><u>BALTIMORE, CITY</u>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><u>215-28-6594</u>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><u>63</u> Yrs.                             | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>06/28/1933</u>                |
|   | 9. Birthplace (State or Foreign Country)<br><u>MARYLAND</u>   |  |  |  |  |  |   |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10e. State<br><u>MARYLAND</u>  |  | 10b. County<br><u>BALTIMORE, CITY</u>  |  | 10c. City, Town or Location<br><u>BALTIMORE</u>                         |
|   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |   |
|   | 10e. Street and Number<br><u>2713 SPELLMAN ROAD</u>   |  | 10f. Zip Code<br><u>21225</u>  |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>   |  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><u>KOREAN WAR</u> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u> |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>0</u>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>HORSE TRAINER</u>                                      |  | 16b. Kind of Business/Industry<br><u>RACE TRACK</u>  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><u>ALBERT BECKWITH</u>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>EVANGELINE FOSTER</u>  |  |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>EVANGELINE FOSTER (MOTHER)</u>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2617 ROUND ROAD BALTIMORE, MARYLAND 21225</u>                      |  |  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>CROWNSVILLE VETERAN CEM</u>   |  | Date<br><u>7/24/96</u>   | 20c. Location - City or Town, State<br><u>CROWNSVILLE, MARYLAND</u>  |   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><u>ESTEP BROTHERS FUNERAL HOME PA.</u><br><u>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</u>  |  |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <u>Respiratory arrest</u><br>Due to (or as a consequence of):<br>b. <u>Sub-acute bronchitis</u><br>Due to (or as a consequence of):<br>c. <u>Squamous cell carcinoma of lung</u><br>Due to (or as a consequence of):<br>d. _____ |  | Approximate Interval Between Onset and Death<br><br><u>minutes</u><br><br><u>10 days</u><br><br><u>1 1/2 months</u>  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Chronic alcoholism - 10+ years</u>   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>Hospice</u> |  |  |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><u>Rolf B. Finn, M.D.</u>   |  | 29c. License number<br><u>D02175</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>7-19-96</u>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Rolf B. Finn, M.D. 8826 Winands Road, Randallstown, MD 21133</u>   |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><u>JUL 24 1996</u>   |   | 32. Registrar's Signature<br>  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed with 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



96 21776

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CATHERINE M. BENSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 17, 1996</b>  |  | 3. TIME OF DEATH<br><b>4:40 A.</b>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-03-2234</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 6, 1901</b>  |  |  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Balto, Md.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Westminster Nursing &amp; Convalescent Cen.</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>  |  |  |  |
| 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |  |  | 10a. STATE<br><b>Md.</b>  |  |  |  |  |  |
| 10b. COUNTY<br><b>City--Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>5219 Florence Ave.</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>9th grade</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                   |  |  |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>E. Paul Murphy</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Agnes V. Willet</b>   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Mary Eileen Weller (Daughter)</b>  |  |  |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3006 Oakford Ave. Baltimore, Md. 21215</b>  |  | 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery 7/20/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md. 21136</b>  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>CEREBRAL VASCULAR - MULTI INFARCT 2 YEARS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>ARTEROSCLEROTIC CARDIOVASCULAR DIS 4 YEARS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  | 29c. LICENSE NUMBER<br><b>D11496</b>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>7/17/96</b>   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DANIEL I. WELLIVEN MD 912 WASHINGTON RD WESTMINSTER MD. 21157</b>  |  | 31. DATE FILED (Month, Day, Year)<br><b>JUL 24 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21777

## Certificate of Death

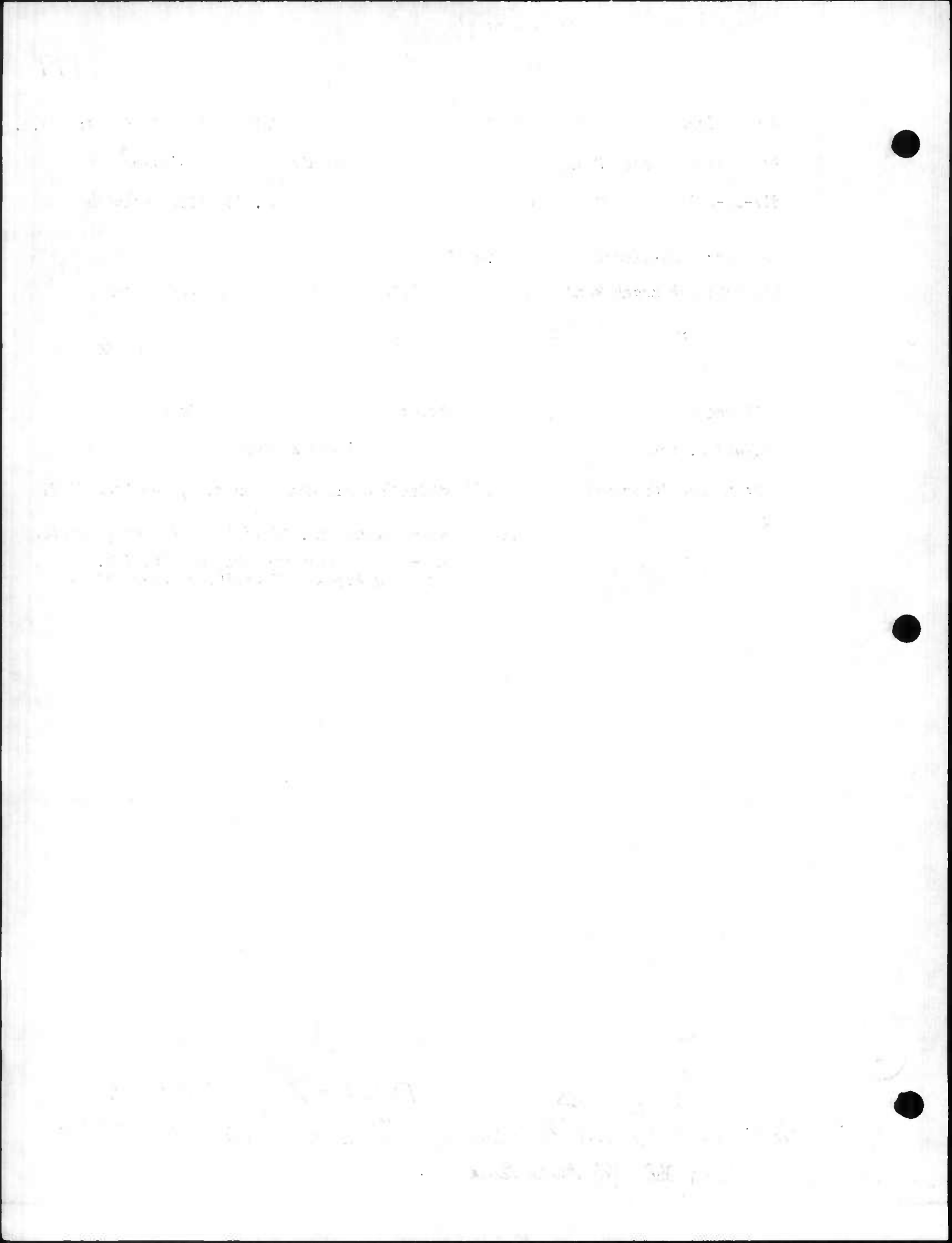
Reg. No.

|   |   |  |   |   |  |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
|---|---|--|---|---|--|--|--|---|--|---|---|--|----------------------------------|--|--|---------------------------------|----|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><del>Joan Cook</del> Joan Estelle Cook                              |  |   |   |  | 2. Date of Death<br>Month Day Year<br>July 19 1996   |  | 3. Time of Death<br>7:50 a.m.   |  |   |   |  |                                  |  |  |                                 |    |    |
|   | 4a. Facility Name (If not institution, give street and number)<br>937 Oakleigh Beach Road                       |  |   |   |  | 4b. City, Town, or Location of Death<br>Dundalk  |  | 4c. County of Death<br>Baltimore  |  |   |   |  |                                  |  |  |                                 |    |    |
| Funeral<br>Director   | 5. Social Security Number<br>218-32-2823  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>60 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 18, 1936                                 |   | 9. Birthplace (State or Foreign Country)<br>Maryland |   |   |  |                                  |  |  |                                 |    |    |
|   | Usual Residence of Decedent<br>10a. State 10b. County 10c. City, Town or Location<br>Maryland Baltimore Dundalk |  |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
| 10e. Street and Number<br>937 Oakleigh Beach Road   |   |  |   |   | 10f. Zip Code<br>21222   |  | 10g. Citizen of What Country?<br>United States                                       |   |  |   |   |  |                                  |  |  |                                 |    |    |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |   |   |  |                                  |  |  |                                 |    |    |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>11 years  |   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary   |  |  | 16b. Kind of Business/Industry<br>Steel   |  |   |   |  |                                  |  |  |                                 |    |    |
| 17. Father's Name (First, Middle, Last)<br>Freidof O. Fondila   |   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Frances Novak   |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
| 19a. Informant's Name/Relationship (Type, Print)<br>Walter Cook (Husband)   |   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>937 Oakleigh Beach Road Dundalk, Maryland 21222   |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sacred Heart of Jesus Cem.  |   |  | Date<br>7/22/96  |  | 20c. Location - City or Town, State<br>Baltimore, Maryland  |  |   |   |  |                                  |  |  |                                 |    |    |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |  |   |   | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Avenue Dundalk, Maryland 21222  |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |   |   |  |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td rowspan="4">}</td> <td>a. <i>Non-small cell carcinoma of the lung</i></td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4"></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <i>with brain metastasis</i></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table> |   |  |   |   |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | } | a. <i>Non-small cell carcinoma of the lung</i> | Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death | b. <i>with brain metastasis</i> | c. | d. |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | }   | a. <i>Non-small cell carcinoma of the lung</i>   | Due to (or as a consequence of):  |   | Approximate Interval Between Onset and Death   |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
|   |   | b. <i>with brain metastasis</i>                  |   |   |  |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
|   |   | c.   |   |   |  |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
|   |   | d.   |   |   |  |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
|   |   |  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |   |  |                                  |  |  |                                 |    |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred                    |   |   |  |                                  |  |  |                                 |    |    |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |   |   |  |                                  |  |  |                                 |    |    |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |   |  |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  |   |   | 29c. License number<br>D33627  |  | 29d. Date signed (Month, Day, Year)<br>7-19-96                                       |   |  |   |   |  |                                  |  |  |                                 |    |    |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Carmen G. Salvaterra 1114 Sandpiper Circle, Ste 212, Catonsville, MD 21228  |   |  |   |   |  |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |
| State Registrar   |   | 31. Date filed (Month, Day, Year)<br>JUL 24 1996 |   | 32. Registrar's Signature<br><i>[Signature]</i> |  |  |  |   |  |   |   |  |                                  |  |  |                                 |    |    |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

12





96 21778

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21779

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |  |  |
|--|---|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><i>Alma Savage Culver</i>   |  |   |  | 2. Date of Death<br>Month <i>July</i> Day <i>23</i> Year <i>1996</i>   |  |   |  | 3. Time of Death<br><i>11:30 AM</i>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>FALLSTON GENERAL HOSPITAL</i>  |  |   |  | 4b. City, Town, or Location of Death<br><i>FALLSTON</i>  |  |   |  | 4c. County of Death<br><i>HARFORD</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>245-14-4211</i>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><i>74</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>FEB. 6, 1922</i>                                  |  | 9. Birthplace (State or Foreign Country)<br><i>NORTH CAROLINA</i>  |  |
|  | 10a. State<br><i>MARYLAND</i>   |  | 10b. County<br><i>HARFORD</i>   |  | 10c. City, Town or Location<br><i>FALLSTON</i>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br><i>1700 PARKVIEW ROAD</i>   |  |   |  | 10f. Zip Code<br><i>21047</i>  |  |   |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12 YRS.</i> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>AT HOME</i>  |  |   |  | 16b. Kind of Business/Industry<br>—  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>GEORGE A. SUMERLIN</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>ALICE M. SAVAGE</i>  |  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>ROBERT J. CULVER</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1700 PARKVIEW ROAD FALLSTON, MARYLAND 21047</i>  |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>DULANEY VALLEY MEMORIAL</i>  |  | Date<br><i>JULY 26 1996</i>  |  | 20c. Location - City or Town, State<br><i>Timonium, MARYLAND</i>                            |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><i>EVANS CHAPEL OF CHIMES<br/>2325 YORK ROAD - Timonium</i>  |  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |   |  |  |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Acute &amp; Chronic Respiratory Failure</i> Days<br>Due to (or as a consequence of):<br>b. <i>Chronic Obstructive Pulmonary Disease</i> Years<br>Due to (or as a consequence of):<br>c. <i>Chronic Asthma</i> Years<br>Due to (or as a consequence of):<br>d. <i>Acute Bacterial Bronchitis</i> Days   |  |   |  |  |  |   |  |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>{<br>e. <i>Rheumatoid arthritis</i><br>f. <i>Osteoporosis</i><br>g. <i>Cushing Disease</i>  |  |   |  |  |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Rheumatoid arthritis</i><br><i>Osteoporosis</i><br><i>Cushing Disease</i>  |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Perfecto C. Valerao, M.D.</i>   |  | 29c. License number<br><i>D16389</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>July 23, 1996</i>                                 |  |  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>PERFECTO C. VALERAO, M.D. 1716 HUNFORD RD Rm 106 FALLSTON MD 21047</i>   |  |   |  |  |  |   |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><i>JUL 24 1996</i>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21780

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>BERTHA CARRINGTON</b>   |  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>19</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>12:11 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>918 N. LUZERNE AVENUE</b>   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N. A.</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219 10 7772</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>2-18-17</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>S.C.</b>  |
|  | Usual Residence of Decedent  |  |   |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>  | 10b. County<br><b>N. A.</b>  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>918 N. LUZERNE AVE</b>  |  |   | 10f. Zip Code<br><b>21205</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> Collage (1-4or 5+)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Patient Aid I</b>  |  | 16b. Kind of Business/Industry<br><b>Depth Hospital</b>  |  |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>Edward Wilson</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Josephine Dukes</b>   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LUCILLE PATTERSON</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>918 N. Luzerne Ave Balt-Md-21205</b> |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cem.</b>  |  | 20c. Location - City or Town, State<br><b>7/26/96 Landsdowne, Md</b>   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Joseph B. Locke Jr</b>   |  |   | 22. Name and Address of Facility<br><b>Locke Funeral Home 1304 N. Central St</b>   |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hypertensive Arteriosclerotic Cardiovascular Disease</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETE</b>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|  |  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|  |  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |
|  |  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| State Registrar  | 29a. Certifier (check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |
|  | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |   | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 19, 1996</b>                                    |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>              |  | 32. Registrar's Signature<br><b>[Signature]</b>                            |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State of Maryland / Department of Health and Mental Hygiene

96 21781

## Certificate of Death

Reg. No.

|  |   |   |                                 |  |  |  |  |   |  |   |  |
|--|---|---|---------------------------------|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>George Carr</b>                                  |   |                                 |  | 2. Date of Death<br>Month <b>July</b> Day <b>22</b> Year <b>96</b> |  | 3. Time of Death<br><b>11:02 AM</b>                        |   |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Liberty Medical Center</b> |   |                                 |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>           |  | 4c. County of Death<br><b>NA</b>                           |   |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-26-8189</b>   |   | 6. Sex<br><b>1</b> M <b>2</b> F |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.                   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 23, 1930</b> |   |  |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |   | 10a. State<br><b>MD</b>         |  | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>            |   |  |   |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |                                 | 10e. Street and Number<br><b>3316 SUMTER AVE</b>   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No <b>WWII</b><br>If Yes, Give Year or Dates:                          |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>      |  |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>NA</b>  |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STEEL WORKER - TIN MILL</b> |                                 | 16b. Kind of Business/Industry<br><b>BERTRAM STEEL</b>   |  |  |  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>UNKNOWN</b>  |   |   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EDNA CARR</b>  |  |  |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Vicki L. McAdams Daughter</b>   |   |   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4803 Gwynn Oak Ave. Balto. Md. 21207</b>                                     |  |  |  |   |  |   |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD. NAT. MEM. PARK</b>   |                                 | 20c. Location - City or Town, State<br><b>7/26/96 LAUREL, Md</b>   |  |  |  |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Theresa B. Harris</b>  |   |   |                                 | 22. Name and Address of Facility<br><b>March Funeral Home - West 4300 Wabash Ave. Balto. Md. 21215</b>   |  |  |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Ventricular Fibrillation</b><br>Due to (or as a consequence of):<br>b. <b>Diabetic Cardiomyopathy</b><br>Due to (or as a consequence of):<br>c. <b>Chronic renal Failure</b><br>Due to (or as a consequence of):<br>d. <b>Septicemia</b> |   |   |                                 |  |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Peripheral vascular disease &amp; amputation Rt foot</b><br><b>Intraabdominal para aortic mass</b>  |   |   |                                 |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |  |   |  |
|  |   |   |                                 |  |  |  |  | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |   |   |                                 | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |  |   |  |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |                                 | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                             |  | 28d. Describe how injury occurred   |  |   |  |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                 |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |                                 | 29b. Signature and title of certifier<br><b>Theresa B. Harris MD</b>   |  |  |  | 29c. License number<br><b>018327</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 22/96</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Moges Gebremariam 4660 Wilkens Ave Balto Md 21229</b>   |   |   |                                 |  |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |   |   |                                 | 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 8760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

21782

|   |  |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|--|---|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>THELMA MAY CRONEY</b>                               |  |  |  | 2. Date of Death<br>Month Day Year<br><b>July 22, 1996</b> |  | 3. Time of Death<br><b>3:30 AM</b>                      |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Bel Forest H Nursing Home</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Forest Hill</b> |  | 4c. County of Death<br><b>Harford</b>                   |  |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>215 07 5964</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>0 9 29 11</b> |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>N/A</b>                                  |  | 10c. City, Town or Location<br><b>Baltimore</b>         |  |  |
| Usual Residence of Decedent   |  |  |  |  |  |  |   |  |  |
| 10a. State<br><b>Md.</b>  |  |  | 10b. County<br><b>N/A</b>  |  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  | 10e. Street and Number<br><b>626 South Savage Street</b>   |  |  | 10f. Zip Code<br><b>21224</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housework</b>  |   |  |  |
| 16b. Kind of Business/Industry<br><b>At Home</b>  |  |  | 17. Father's Name (First, Middle, Last)<br><b>Henry McNew</b>  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Fraas</b>   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dennis J. Croney, Son</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2230 Larchmont Drive Fallston, Md. 21047</b>   |  |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>   |  |  | 20c. Location - City or Town, State<br><b>7-24-96 Eastwood, Md.</b>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Charles S. Zeiler</b>   |  |  | 22. Name and Address of Facility<br><b>Charles S. Zeiler &amp; Son Inc.<br/>6224 Eastern Ave. Balto., Md.</b>  |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Chronic obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br>b. <b>Cerebrovascular accident</b><br>Due to (or as a consequence of):<br>c. <b>Congestive heart failure</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  |  |  |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  | 28a. Date of Injury (Month, Day Year)  |  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28d. Describe how injury occurred  |  |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Thahmmy my</b>  |  |  | 29c. License number<br><b>D45921</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>7.23.96</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SYED F. MAHMOOD M.D. 4-C NORTH AVE SUITE 424 BELAIR MD 21014</b>   |  |  |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |  |  |  |  |  |  |   |  |  |
| 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21783

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Loretta Elizabeth CLAPIN</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>July 22, 1996</b>  |  | 3. Time of Death<br><b>5:18 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin A Square Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Rossville</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212 09 1038</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>08 04 13</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Essex</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>1021 Foxcroft Lane</b>   |  | 10f. Zip Code<br><b>21221</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)                       |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housework</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>At Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Christian Krug</b>  |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Work</b>   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles G. Clapin, Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1021 Foxcroft Lane Essex, Md. 21221</b>       |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>7-26-96 Eastwood, Md.</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Charles S. Zeiler &amp; Son Inc.<br/>6224 Eastern Ave. Balto., Md.</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial infarction</b><br>Due to (or as a consequence of):<br><b>b. Coronary artery disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Approximate Interval Between Onset and Death<br><b>30 minutes</b><br><b>30 years</b> |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |
|   | 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>D26116</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 22, 1996</b>   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Laurie Harris 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |  |   |  |
|   | 32. Registrar's Signature<br>   |  |  |  | 33. Registrar's Name<br><b>Julia Anderson-Randall</b>   |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene 96 21784

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Martha R. Crouse

2. Date of Death  
Month Day Year  
July 19, 19963. Time of Death  
5:15 P.M.Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

8250 Quarterfield Road

4b. City, Town, or Location of Death

Severn

4c. County of Death

Anne Arundel

5. Social Security Number

219-22-7963

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec 26, 1924

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8250 Quarterfield Road

10f. Zip Code

21144

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Pearl G. Bryant

18. Mother's Name (First, Middle, Maiden Surname)

Ruth I. Spencer

19a. Informant's Name/Relationship (Type, Print)

Paul L. Crouse -- Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8250 Quarterfield Road, Severn Maryland 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland State Vets Cem

Date

7/23/96

20c. Location - City or Town, State

Crownsville Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

George J. Gonce Funeral Home

4001 Ritchie Highway Baltimore Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)a.  Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

3/96

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

918508

29d. Date signed (Month, Day, Year)

7-22-96

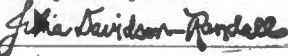
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CHARLES J. WIL MD 1600 S. CRAN HWY #306 GLEN BURNIE MD 21061

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

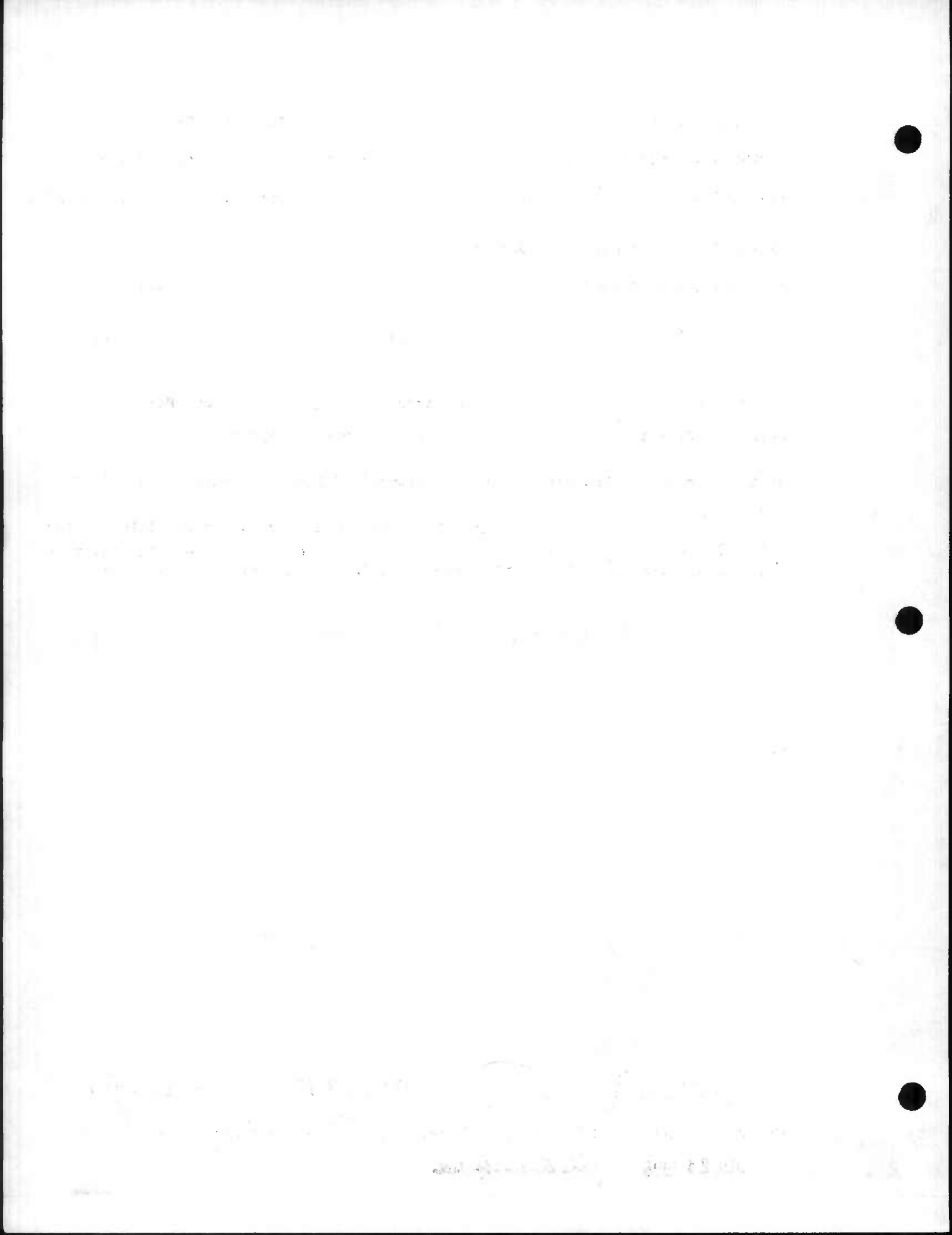
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



96 21785

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>REGINALD J. CARTER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>19</b> YEAR <b>1996</b>   |  |  |  | 3. TIME OF DEATH<br><b>2:45p M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-62-3619</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>41</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10 1 1954</b>                           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2127 CHRISTIAN STREET</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>N/A</b>   |  |
| RESIDENCE OF DECEASED  |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>2127 CHRISTIAN STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>21229</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>           |  |   |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-0-</b>   |  |  |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>GARDNER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>LANDSCAPING</b>                                 |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH CARTER SR.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FRANCES BURTON</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>FRANCES CARTER (MOTHER)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1842 JOHN DRIVE EDGEWOOD, MD. 21040</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FRST. VET.CEM 7/25/96</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE</b>   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> CFSP #281  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. PHILLIPS F/H<br/>1721-27 N. MONROE STREET BALTIMORE, MD.</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>Pneumonia</b><br><b>Acquired Immune Deficiency</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>2 wks</b><br><b>10 wks</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Christa Lamping MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D32263</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/22/96</b>                                |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>1940 W Baltimore Baltimore MD 21223</b>  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 24 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

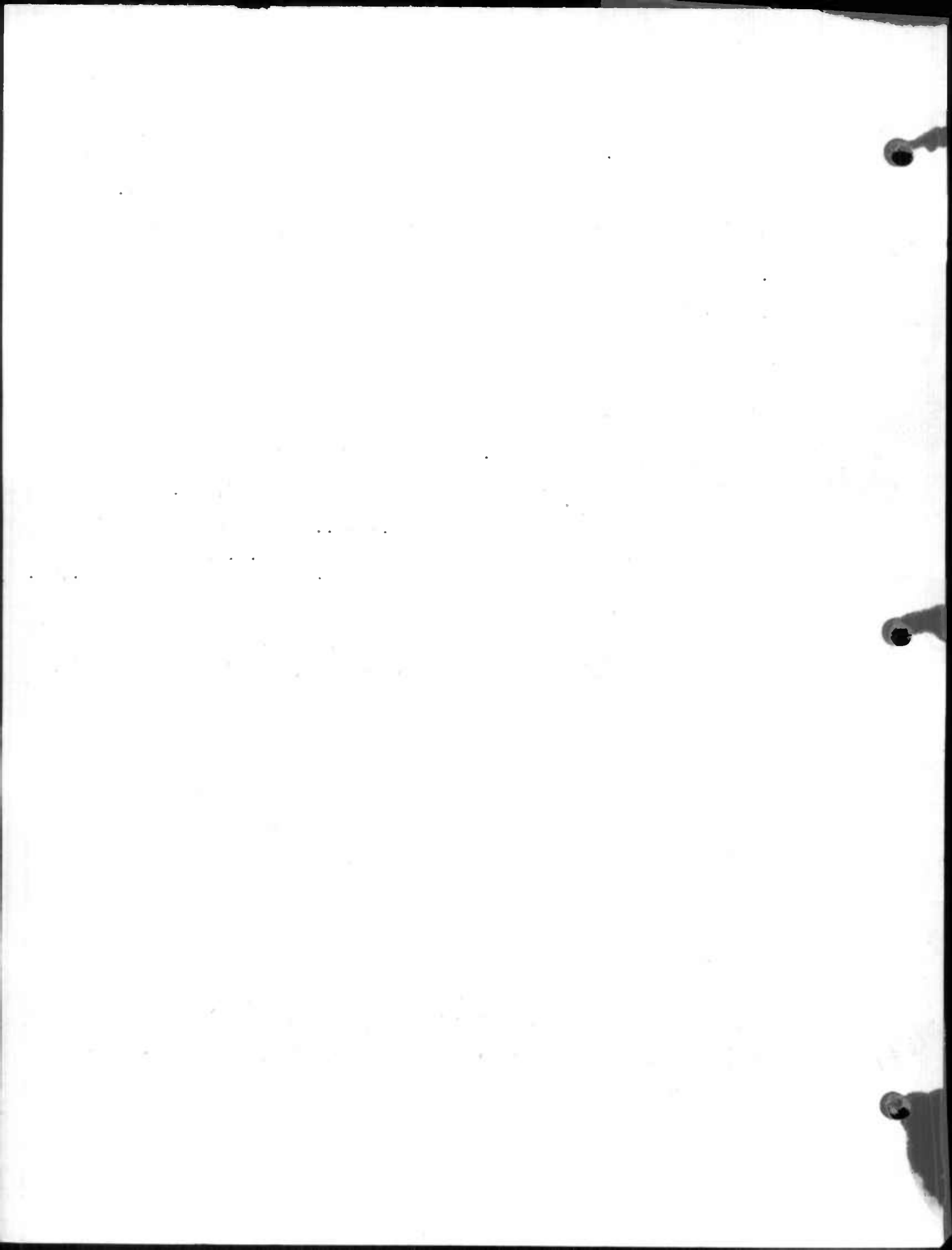
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The undersigned certifies that the death certificate was executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21786

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |   |  |  |
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| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>SHIRLEY J CORNISH</b>  |  |   | 2. Date of Death<br>Month Day Year<br><b>JULY 21, 1996</b>    |  | 3. Time of Death<br><b>0120AM</b>       |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL E.R.</b>   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b> |  | 4c. County of Death<br><b>BALTIMORE</b> |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-38-6858</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>MAY 25, 1937</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>BALTIMORE</b>  |   | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |  |
| To Be Completed by Funeral Director                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1003 BRISTOL PLACE</b>   |   | 10f. Zip Code<br><b>21225</b>  |   | 10g. Citizen of What Country?<br><b>USA.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| To Be Completed by Physician/Medical Examiner                        | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>11+H GRADE</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NURSE</b>   |   | 16b. Kind of Business/Industry<br><b>BALTO. CITY HEALTH DEPT.</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>FREDRICK COOK</b>  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DOROTHY SEDGWICK</b>  |  | 19. Informant's Name/Relationship (Type, Print)<br><b>TINA CORNISH</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>957 JACK STREET, BALTIMORE, MD. 21216</b>  |   | 20. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| Physician<br>/Medical<br>Examiner                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT ZION CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |   | 21. Signature of Funeral Service Licensee<br><b>JOSEPH H. BROWN JR.</b>  |   | 22. Name and Address of Facility<br><b>2140 N. FULTON AVE, BALTIMORE, MD. 21217</b>  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ATHROSCYTIC CARDIOVASCULAR DISEASE</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)   |  |
|  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how Injury occurred  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| State Registrar  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Harold A. Brown</b>   |   | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 21, 1996</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARYLAND D. KOSAR MD</b>   |  | 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |   | 32. Registrar's Signature<br><b>Julia Davidson</b>   |   | 33. Date of Death<br><b>111 Penn Street, Baltimore, Maryland 21201</b>   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 2 should be detached for use as the burial-transit

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

|  |  |  |  |   |  |  |   |   |  |
|--|--|--|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN GOLDIE DOANS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>JULY</b> DAY <b>8</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>2430 A M</b>  |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>111-09-1401</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>DEC. 5, 1910</b>                           |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LORIE NURSING HOME</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COLUMBIA</b>  |  |  |   | 9c. COUNTY OF DEATH<br><b>HOWARD COUNTY</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>RANDALLSTOWN</b>  |  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>23 SPYCE MILL COURT</b>   |  |  |  | 10f. ZIP CODE<br><b>21133</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                   |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12+H GRADE</b><br>College (1-4 or 5+) <b>KEY PUNCH OPERATOR</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>GOVERNMENT</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES SMITH</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY GAYLE</b>  |  |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CHERRIE JOYCE BROOKS</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23 SPYCE MILL CT. RANDALLSTOWN, MD. 21133</b>   |  |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. CALVARY CEMETERY 7-12-96 GLEN BURNIE, MD.</b>  |  | DATE  |  | 20c. LOCATION — City or Town, State  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH H. BROWN JR. FUNERAL HOME<br/>2140 N. FULTON AVE., BALTIMORE, MD 21217</b>  |  |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br>a. <b>RENAL FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>NEPHROTIC SYNDROME</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>6 months</b><br><b>1 year</b>                          |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>- CONGESTIVE HEART FAILURE due to Hypertension</b><br><b>- DEMENTIA (ALZHEIMER type)</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |   |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>MD 25210</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/9/96</b>                                 |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. JERRY SEALS, 3460 ELLICOTT CENTER DR., ELLICOTT CITY, MD. 21043</b>  |  |  |  |   |  |  |   |   |  |
| 31. DATE (Month, Day, Year)<br><b>JUL 24 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |   |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21788

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Elsie Catherine Eibner</b>  |  |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>18</b> Year <b>1996</b>  |  |   |  | 3. Time of Death<br><b>7:00 a.m.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>5530 Force Road</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-30-3545</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 10, 1933</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | Usual Residence of Decedent  |  |  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>                             |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>5530 Force Road</b>  |  |   |  | 10f. Zip Code<br><b>21206</b>  |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>12 years</b>   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |   |  | 17. Father's Name (First, Middle, Last)<br><b>William Adams</b>  |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian Panzer</b>   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Leo W. Eibner (Husband)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5530 Force Road Baltimore, Maryland 21206</b>  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  |   |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Charles W. Fisher</i>  |  |  |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Avenue Dundalk, Maryland 21222</b>   |  |   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic Lung Carcinoma</b>                              |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)   |  |  |  | 28b. Time of Injury<br><b>M</b>   |  |   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br><i>Paul Vallejo MD</i>   |  |   |  | 29c. License number<br><b>026835</b>   |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>7/19/96</b>  |  |  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Paul Vallejo MD 1062 Northpoint Rd Balto MD 21224</b>  |  |   |  | 31. Data filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |  |
|   | 32. Registrar's Signature<br><i>Julia Davidson-Rondella</i>  |  |  |  | 33. Registrar's Title<br><b>State Registrar</b>   |  |   |  | 34. Registrar's Address<br><b>10</b>   |  |



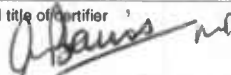
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State of Maryland / Department of Health and Mental Hygiene

96 21789

## Certificate of Death

Reg. No.

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|--|--|--|---|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Orangie W. Epps  |  |   |  | 2. Date of Death<br>Month Day Year<br>JULY 19TH 1996  |  |   |  | 3. Time of Death<br>2:00 AM  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Union Memorial Hospital  |  |   |  | 4b. City, Town, or Location of Death<br>Baltimore City  |  |   |  | 4c. County of Death<br>N/A   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-40-4581   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>91 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>12 18 1904 |  | 9. Birthplace (State or Foreign Country)<br>MD.                                      |  |  |  |
|  | Usual Residence of Decedent  |  |   |  | 10a. State<br>MD.   |  | 10b. County<br>N/A                                |  | 10c. City, Town or Location<br>BALTIMORE   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br>3939 ROLAND AVE. APT. 717  |  |   |  | 10f. Zip Code<br>21211  |  |   |  | 10g. Citizen of What Country?<br>US  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                     |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4  |  |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>TEACHER  |  |   |  | 16b. Kind of Business/Industry<br>EDUCATION  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>SAMUEL WISE   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>EFFIE COHEN  |  |   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>MILDRED JONES (DAUGHTER)   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3513 GELSTON DRIVE BALTIMORE, MD. 21229  |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MT. AUBURN CEMETERY   |  |   |  | Date<br>7/24/96  |  | 20c. Location - City or Town, State<br>BALTIMORE, MD.  |  |
|  | 21. Signature of Funeral Service Licensee<br> CFSP #281  |  |   |  | 22. Name and Address of Facility<br>E.L. PHILLIPS FUNERAL HOME<br>1721-27 N. MONROE ST. BALTIMORE, MD. 21217  |  |   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. SEPTIC SHOCK<br>Due to (or as a consequence of):<br>b. URINARY TRACT INFECTION<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |   |  |   |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CEREBROVASCULAR ACCIDENT<br>HTN, ATRIAL FIBRILLATION   |  |   |  |   |  |   |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                          |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br>A 2438946   |  | 29d. Date signed (Month, Day, Year)<br>7/19/96 July  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>ARVINDER BAINS, DEPT MEDICINE, UNION MEMORIAL HOSP., BALTIMORE, MD 21218   |  |   |  |   |  |   |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br>JUL 24 1996   |  |   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21790  
item#26, filing 737, 7/24/96, cyw, per doctor  
Certificate of Death

Reg. No.

|   |   |  |  |   |  |  |  |  |
|---|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Bonnie Ervin</b>                         |  |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>11</b> Year <b>1996</b> |  | 3. Time of Death<br><b>7:38 AM</b>                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>             |  | 4c. County of Death<br><b>N/A</b>                                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-362969</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>53</b> Yrs.                     |  | 8. Date of Birth<br>Month <b>Nov.</b> Day <b>26</b> Year <b>1942</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>                       |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>                      |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>2405 Shirley Ave.</b>  |  | 10f. Zip Code<br><b>21215</b>  |  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Negro</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurses Assistant</b>              |  | 16b. Kind of Business/Industry<br><b>Nursing Home</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alton Ervin</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Wilhelmina Kirven</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. moredon DATE meretta Ervin</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2405 Shirley Ave. Baltimore Md. 21215</b>     |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cem</b>  |  | 20c. Date<br><b>7/8/96</b>  |  | 20d. Location - City or Town, State<br><b>Lansdowne Md.</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>  |   |  |  | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</b>                                    |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |   |  |  |   |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>2 days</b>   |   |  |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>morbid obesity</b>   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |   |  |  |   |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 28d. Describe how injury occurred   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br><b>Elliot Rothschild medical Resident</b>   |  | 29c. License number<br><b>AS2402321ER9943</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 11, 1996</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Elliot Rothschild Sinai Hospital</b>   |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |   |  |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21791

MEO FILM G-738 8/15/96 t.t

## Certificate of Death

Reg. No.

|  |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|--|---|---------------------------------------|---|--|--|--|--|--|---|---|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|-------------------------------------|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH R. FITZGERALD JR.</b>   |                                       |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>16</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>18:04 P</b>   |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1328 MCCULLOUGH ST.</b>  |                                       |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-43-9591</b>   |                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>1</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>12-21-1994</b>                                       |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | Usual Residence of Decedent   |                                       | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>   |                                       | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 10e. Street and Number<br><b>1328 MCCULLOUGH STREET</b>   |                                       | 10f. Zip Code<br><b>212</b>   |  | 10g. Citizen of What Country?<br><b>USA.</b>   |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)   |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>N/A</b>                           |  | 16b. Kind of Business/Industry<br><b>N/A</b>   |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH FITZGERALD</b>   |                                       |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JENNIFER E. McLAUGHLIN</b>   |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ASENATH MITCHELL</b>   |                                       |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4727 MIDWOOD AVENUE, BALTIMORE MD. 21212</b>   |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>  |  | 20c. Location - City of Town, State<br><b>7-26-96 BALTIMORE, MD.</b>   |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |                                       |   |  | 22. Name and Address of Facility<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | <table border="1"> <tr> <td rowspan="4">ImmEDIATE Cause (Final disease or condition resulting in death)</td> <td colspan="7">a. <b>BLUNT FORCE INJURIES COMPLICATING MYOCARDITIS</b></td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="8">d. Due to (or as a consequence of):</td> </tr> </table> |                                       |   |  |  |  |  |  | ImmEDIATE Cause (Final disease or condition resulting in death) | a. <b>BLUNT FORCE INJURIES COMPLICATING MYOCARDITIS</b> |  |  |  |  |  |  | Due to (or as a consequence of): |  |  |  |  |  |  | b. Due to (or as a consequence of): |  |  |  |  |  |  | c. Due to (or as a consequence of): |  |  |  |  |  |  | d. Due to (or as a consequence of): |  |  |  |  |  |  |
| ImmEDIATE Cause (Final disease or condition resulting in death)  | a. <b>BLUNT FORCE INJURIES COMPLICATING MYOCARDITIS</b>   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | Due to (or as a consequence of):  |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | b. Due to (or as a consequence of):   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
|  | c. Due to (or as a consequence of):   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| d. Due to (or as a consequence of):  |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>FOUND 7/16/96</b>   |   | 28b. Time of Injury<br><b>4:30 PM</b> |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred<br><b>SUBJECT STRUCK WITH BLUNT OBJECT</b> |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND AT HOME</b>   |   |                                       |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1328 MC CULLOUGH ST.<br/>2ND FLOOR, BALTIMORE, MARYLAND</b> |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |                                       |   | 29c. License number<br><b>O.C.M.E</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 17, 1996</b>                  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING, 111 Penn Street, Baltimore, Maryland 21201</b>  |   |                                       |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |   | 32. Registrar's Signature<br>         |   |  |  |  |  |  |   |   |  |  |  |  |  |  |                                  |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |                                     |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

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## Certificate of Death

Reg. No.

|   |   |  |  |  |   |
|---|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN J GOETZ Sr.</b>   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>21</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>0540AM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3547 HORTON AVENUE</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death<br><b>N/A</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217 72 7140</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.   | If Under 1 Year<br>Months <b>0</b> Days <b>0</b> | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>May 6, 1958</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 10e. State<br><b>Maryland</b>   | 10b. County<br><b>N/A</b>  |  |  |   |
|   | 10e. Street and Number<br><b>3547 Horton Avenue</b>   |  | 10f. Zip Code<br><b>21225</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dock Worker</b>                      |  | 16b. Kind of Business/Industry<br><b>Trucking Company</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>John H. Goetz</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary E. Sparks</b>   |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>John H. Goetz</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3547 Horton Avenue Baltimore, Maryland 21225</b> |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>7/24/96 Baltimore, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>                                     |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. NARCOTIC INTOXICATION</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |   |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined   |   |  |  |  |   |
| 28a. Date of Injury (Month, Day, Year)<br><b>UNKNOWN</b><br><b>FOUND 7/21/96</b>  |   |  |  |  |   |
| 28b. Time of Injury<br><b>UNKNOWN</b><br><b>FOUND 5:30M</b>   |   |  |  |  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |   |
| 28d. Describe how injury occurred<br><b>UNKNOWN</b>   |   |  |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND AT RESIDENCE</b>   |   |  |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>3547 HORTON AVE. BALTIMORE, MD. 21225</b>  |   |  |  |  |   |
| 29e. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |   |
| 29b. Signature and title of certifier<br>  |   |  |  |  |   |
| 29c. License number<br><b>O.C.M.E.</b>  |   |  |  |  |   |
| 29d. Date signed (Month, Day, Year)<br><b>JULY 21, 1996</b>   |   |  |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>M. K. Korow 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |   |  |  |  |   |
| 32. Registrar's Signature<br>  |   |  |  |  |   |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This certificate must be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BOSIE B. GATES</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>JULY</b> DAY <b>19</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>7 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-12-7176</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>08 23 1914</b>  |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>VILLA ST. MICHAELS NURSING HOM.</b>   |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 10. COUNTY OF DEATH<br><b>N/A</b>  |  |
| 11. RESIDENCE OF DECEDENT<br>10a. STATE<br><b>MD.</b>   |  |  |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>4800 YELLOWOOD AVE.</b>   |  | 10f. ZIP CODE<br><b>21215</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  | 15. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>NURSE</b>                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>   |  |  |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>MEDICINE</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>MARSHALL THOMPSON</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>EDNA MACKELL</b>  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>CLAUDIA SOLLER (NEICE)</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5507 WINTON AVE BALTIMORE, MD. 21207</b> |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEM. 7/24/96 BALTIMORE, MD.</b>  |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> CFSP#281  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. PHILLIPS F/H 1721-27 N. MONROE STREET BALTIMORE, MD.</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Gastric Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death: <b>7 yrs</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD  |  |  |  | 29c. LICENSE NUMBER<br><b>D15872</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 19 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Harold Bob No 7220 Park Heights 21208</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 24 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





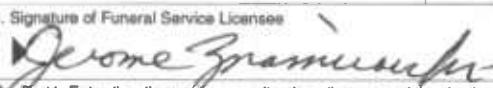

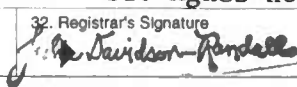
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21794

## Certificate of Death

Reg. No.

|   |   |                                    |  |  |  |   |  |  |   |   |  |
|---|---|------------------------------------|--|--|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL HAAS</b>                             |                                    |  |  |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>16</b> Year <b>1996</b> |  | 3. Time of Death<br><b>16:40</b>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b> |                                    |  |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>             |  | 4c. County of Death<br><b>N/A</b>                                       |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>245 64 4650</b>   |                                    | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>March 12, 1944</b>         |  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>       |   |  |
|   | Usual Residence of Decedent   |                                    |  |  |  |   |  |  |   |   |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Anne Arundel</b> |  | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |   |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                          |   |   |  |
| 10a. Street and Number<br><b>6420 Centennial Circle Apt. A</b>  |   |                                    |  | 10f. Zip Code<br><b>21061</b>  |  |   | 10g. Citizen of What Country?<br><b>U.S.</b>                         |  |   |   |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |   |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:         |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+) 4 years</b>   |   |                                    |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Warehouseman</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>Department Store</b>                    |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>John G. Haas</b>  |   |                                    |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Colleen Williams</b>  |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Brooks Arnold</b>  |   |                                    |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21061 6420 Centennial Circle Apt. A Glen Burnie, Md.</b> |  |  |   |   |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |   |                                    |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>   |  | Date<br><b>7/19/96</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>            |   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |                                    |  |  |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>  |  |  |   |   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |                                    |  |  |  |   |  |  |   | Approximate Interval Between Onset and Death  |  |
| Immediate Cause (Final disease or condition resulting in death)   |   |                                    |  |  |  |   |  |  |   | hours   |  |
| e. <b>Bleeding esophageal varices</b><br>Due to (or as a consequence of):   |   |                                    |  |  |  |   |  |  |   |   |  |
| b. <b>End stage alcoholic liver disease</b><br>Due to (or as a consequence of):   |   |                                    |  |  |  |   |  |  |   | years   |  |
| c.<br>Due to (or as a consequence of):  |   |                                    |  |  |  |   |  |  |   |   |  |
| d.<br>Due to (or as a consequence of):  |   |                                    |  |  |  |   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hepatic encephalopathy</b>   |   |                                    |  |  |  |   |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> Probably <b>4</b> Unknown   |   |                                    |  |  |  |   |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> No  |   |                                    |  |  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> No |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No  |   |                                    |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |  |  |   |   |  |
| 27. Manner of Death<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |   |                                    |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                             |   | 28d. Describe how injury occurred   |  |
|   |   |                                    |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                                    |  |  |  |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br>  |   |                                    |  |  |  | 29c. License number<br><b>D30802</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 17, 1996</b>                  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jean M. Colandrea, M.D. - St. Agnes Hospital - 900 Caton Ave., Baltimore, Md. 21229</b>  |   |                                    |  |  |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |   |                                    |  | 32. Registrar's Signature<br>   |  |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After a death certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

item #24a, filing 737, 1/24/96, C/W, per ME

State of Maryland / Department of Health and Mental Hygiene

96 21795

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |  |  |
|---|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLOTTE BURNETT HALE</b>  |  |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>14</b> Year <b>96</b>   |  |   |  | 3. Time of Death<br><b>5:35 P.M.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Stellar Maris-Mercy Hospice</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-52-4448</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 29, 1950</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | Usual Residence of Decedent  |  | 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>715 N. Port Street</b>  |  |   |  | 10f. Zip Code<br><b>21205</b>  |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+) <b>-</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housekeeping</b>   |  |   |  | 16b. Kind of Business/Industry<br><b>various</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Owen Gardner</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Jackson</b>  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph McPherson</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>150 Carver Road, Baltimore, Maryland 21222</b>   |  |   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>   |  | Date<br><b>7-18</b>  |  | 20c. Location - City or Town, State<br><b>RANDALLSTOWN, MD</b>                              |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>March Funeral Home</b><br><b>1101 E. North Avenue, Baltimore, MD 21202</b>  |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC BREAST CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>4 YEARS</b>   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |  |  |
|   |  |  |   |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings evaluable prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                                  |  | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>        |  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28e. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>                      |  | 29c. License number<br><b>040480</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 15, 1996</b>                                 |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FERNANDO J. FERRO, MD</b><br><b>5810 BELAIR RD.</b><br><b>BALTO., MD 21206</b>  |  |   |  |  |  |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |  |   |  | 32. Registrar's Signature<br>   |  |   |  |  |  |
|   |  |  |   |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21796

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter

2. Date of Death

Month

Day

Year

3. Time of Death

8:40A

4a. Facility Name (If not institution, give street and number)

JOSEPH RITCHIE HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE, CITY

Funeral  
Director

5. Social Security Number

218-07-7513

6. Sex

M 2 F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

1/10/1900

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE, CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1010 WEST BALTIMORE STREET

APT. 504

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PORTER

16b. Kind of Business/Industry

GOVERNMENT HOSPITAL

17. Father's Name (First, Middle, Last)

HENRY HOWIE

18. Mother's Name (First, Middle, Maiden Surname)

MARY HOWIE

19a. Informant's Name/Relationship (Type, Print)

MARY CHEESEBORO (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1010 WEST BALTIMORE STREET BALTIMORE, MARYLAND 21223

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MOUNT ZION CEMETERY 7/27/96

Date

20c. Location - City or Town, State

LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME PA.

1300 EUTAW PLACE BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CARCINOMA OF PROSTATE  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ULINARY TRACT INFECTION 2° OBSTRUCTIVE UROPATHY

PARANEPLA 2° METASTATIC SPINAL CORD COMPRESSION

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 12399

29d. Date signed (Month, Day, Year)

JULY 24, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES O'DONNAN J.R. RICHIE HOSPICE 820 N. EUTAW ST. BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

Julia Burton-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2055.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21797

|   |   |  |  |                                |  |
|---|---|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CORA Estelle HARRISON</b>  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 22, 1996</b>   |                                | 3. Time of Death<br><b>7:40 AM</b>   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>ST. JOSEPH MEDICAL CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |                                | 4c. County of Death<br><b>BALTIMORE</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-12-7503</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Dec 23, 1923</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |                                |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |  |                                |  |
|   | 10e. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Towson</b>   |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>8317 Pleasant Plains Road</b>  |  | 10f. Zip Code<br><b>21286</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                            |                                | 16b. Kind of Business/Industry<br><b>In Own Home</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>James L. Shipley</b>  |  | 18. Mother's Name (First, Middle, Surname)<br><b>Emma E. Richardson</b>  |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ruth Hull (Sister)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8317 Pleasant Plains Road Towson, Maryland 21286</b> |                                |  |
|   | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pruid Ridge Cemetery</b>  |                                | 20c. Location - City or Town, State<br><b>7/25/96 Pikesville, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Burgee-Henss Funeral Home<br/>3631 Falls Road Baltimore, Maryland 21211</b>                                       |                                |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE CEREBROVASCULAR ACCIDENT</b><br>Due to (or as a consequence of):<br><b>b. DIABETES MELLITUS</b><br>Due to (or as a consequence of):<br><b>c. CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |  |                                |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |                                |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |   |  |  |                                |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined   |   |  |  |                                |  |
| 28a. Date of Injury (Month, Day, Year)  |   |  |  |                                |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |  |                                |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |                                |  |
| 28d. Describe how Injury occurred   |   |  |  |                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |                                |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |                                |  |
| 29b. Signature and title of certifier<br><b>Natividad D. de Leon, M.D.</b>  |   |  |  |                                |  |
| 29c. License number<br><b>19508</b>   |   |  |  |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>22nd, July 1996</b>   |   |  |  |                                |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>NATIVIDAD D. DELEON, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204</b>  |   |  |  |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |   |  |  |                                |  |
| 32. Registrar's Signature<br>  |   |  |  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar

1. The first part of the report  
describes the general situation  
of the country and the  
state of the economy.

2. The second part of the report  
describes the results of the  
survey and the findings of the  
research.

3. The third part of the report  
describes the conclusions of the  
research and the recommendations  
for further action.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21798

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |                                |  |  |
|--|---|--|---|---|--|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>GEORGINA LUCRETIA JESSUP  |  |   |   | 2. Date of Death<br>Month Day Year<br>JULY 19 96   |                                | 3. Time of Death<br>9:37 PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>ER FALLSTON GEN. HOSPITAL   |  |   |   | 4b. City, Town, or Location of Death<br>EDGEWOOD   |                                | 4c. County of Death<br>HARFORD   |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-44-9758  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>51 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br>JUNE 14, 1945  | 9. Birthplace (State or Foreign Country)<br>MD |
|  | Usual Residence of Decedent   |  |   |   |  |                                |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD  |  | 10b. County<br>HARFORD  |   | 10c. City, Town or Location<br>EDGEWOOD  |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>903 Woodbridge Ct. #M   |  |   |   | 10f. Zip Code<br>21040   |                                | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th  |  | College (14 or 5+)<br>NA  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>INSURANCE AGENT   |                                | 16b. Kind of Business/Industry<br>Insurance  |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br>GEORGE H. PARRISH  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>RUBY LEE PARRISH  |                                |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Melissa Jessup-Daugh  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>903 Woodbridge Ct. Apt. M Edgewood md 21040   |                                |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>King Mem. Pk  |   | 20c. Date<br>7/25/96   |                                | 20d. Location - City or Town, State<br>Randallstown, md  |  |
|  | 21. Signature of Funeral Service Licensee<br>Phyllis B. Harris  |  | 22. Name and Address of Facility<br>March Funeral Home-West<br>4300 Wabash Ave Balto md. 21215  |   |  |                                |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. ACUTE CORONARY ARTERY DISEASE<br>Due to (or as a consequence of):<br>b. AOWD<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |   |   |  |                                |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |  |                                |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |                                |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br>NA   |   | 28b. Time of Injury<br>NA M  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |  |
|  | 28d. Describe how injury occurred<br>NA   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>NA  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>NA   |                                |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                               |  |   |   |  |                                |  |  |
| State<br>Registrar   | 29b. Signature and title of certifier<br>Phyllis B. Harris OME  |  | 29c. License number<br>OCME   |   | 29d. Date signed (Month, Day, Year)<br>JULY 19 1996  |                                |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>G PRABHU 1810 BELAIR RD FALLSTON MD 21047 410 879 6564  |  |   |   |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1996                     |   | 32. Registrar's Signature<br>John Davidson-Randall |   |   |  |                                |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21799

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Joyce GERALDINE Johnson  |  |   |  |  | 2. Date of Death<br>Month Day Year<br>July 21, 1996  |  | 3. Time of Death<br>5:30 pm  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Johns Hopkins Bayview Medical Center   |  |   |  |  | 4b. City, Town, or Location of Death<br>Baltimore  |  | 4c. County of Death<br>NA  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-44-7243   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>46 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Mar. 24, 1945   |  | 9. Birthplace (State or Foreign Country)<br>N.C. |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD   |  | 10b. County<br>NA   |  | 10c. City, Town or Location<br>BALTIMORE   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
|  | 10e. Street and Number<br>2211 ELSINORE AVE  |  |   |  | 10f. Zip Code<br>21216   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+) 3 years   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Salesperson - Self Employed |  |  | 16b. Kind of Business/Industry<br>Women Clothing Shop  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>William FORBES  |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>HATTIE NEWTON   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>LONGWORTH JOHNSON - Husband  |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2211 ELSINORE AVE. BALTO. MD. 21216 |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>King Memorial Park   |  | Date<br>7-26-96  |  | 20c. Location - City or Town, State<br>RANDALSTOWN MD  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Stephen B. Jarvis   |  |   |  | 22. Name and Address of Facility<br>March Funeral Home - West<br>4300 Wabash Ave Balto md. 21215   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. sepsis<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. renal failure<br>Due to (or as a consequence of):<br>c. exfoliative dermatitis<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>2 days<br>11 days<br>11 days<br>this episode |  |   |  |  |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |  |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                            |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                |  |
|  |  |  | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  | 29b. Signature and title of certifier<br>[Signature]  |  |  | 29c. License number<br>N5444   |  | 29d. Date signed (Month, Day, Year)<br>July 22, 1996   |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br>2 Wyckwood Ct # 202 Baltimore MD.  |  |  | Johns Hopkins Bayview Medical Center<br>4940 Eastern Avenue, Baltimore, MD  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1996   |  |  | 32. Registrar's Signature<br>[Signature]  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21800

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Washington JARVIS

2. Date of Death

Month Day Year  
July 20, 1996

3. Time of Death

10:59 a.m.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore

5. Social Security Number

236-28-1993

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12/20/24

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7800 St. Gregory Drive

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8 years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Welder

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

Jessie G. Jarvis

18. Mother's Name (First, Middle, Maiden Surname)

Nancy E. Jenkins

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Staggs (Stepfather)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1516 Eagle Rock Road Wendell, N. C. 27591

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens

Date

7/23/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Avenue Dundalk, Maryland 21222

23a-Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Renal Cell Cancer with Metastasis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

36 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RD01916

29d. Date signed (Month, Day, Year)

7/20/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. M. Emdadul Haque 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

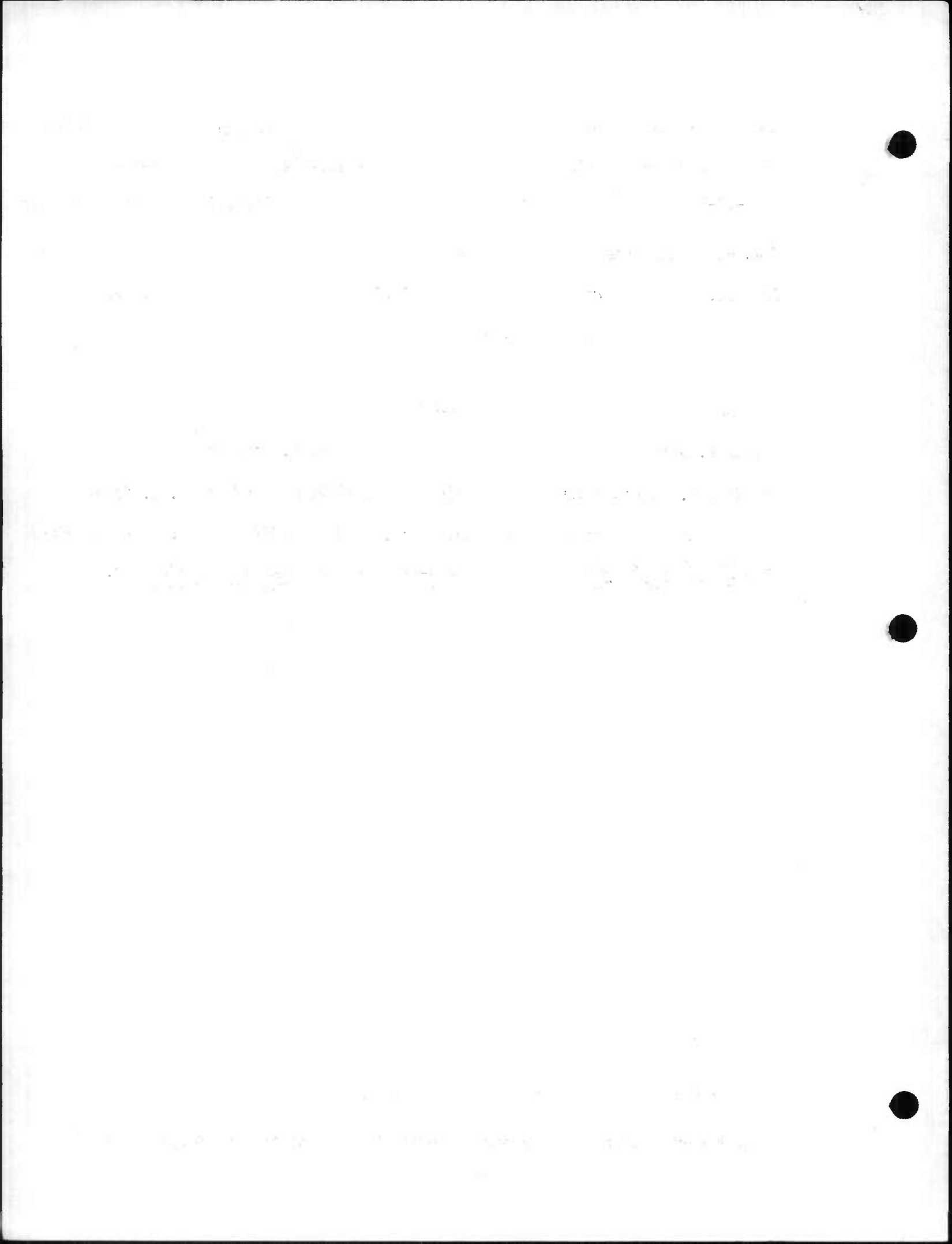
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21801

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MICHAEL LeROY KOSMICKI

2. Date of Death

July 19, 1996

3. Time of Death

7:25 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

216 78 8548

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05 13 58

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1226 Steelton Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Jack Kosmicki

18. Mother's Name (First, Middle, Maiden Surname)

Shirley Biller

19a. Informant's Name/Relationship (Type, Print)

Mary Riley, Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1215 Joplin Street Balto., md. 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 7-23-96 Balto., Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Charles S. Zeiler

22. Name and Address of Facility

Charles S. Zeiler & Son Inc.  
6224 Eastern Ave. Balto., Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. head injury /  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

CERTIFICATION APPROVED BY MEDICAL EXAMINER

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Huntingtons disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

July 18 1996

28b. Time of Injury

6:00 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

Subject fell

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6435 Wiskey Street

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

A04147357

29d. Date signed (Month, Day, Year)

July 23, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mike Chen 3801 Canterbury Rd #411 Baltimore MD 21218

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please it should be detected for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21802

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |  |   |   |
|---|--|---|---|---|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>PERRIN <i>Perrin</i> LEE   |   |   |   | 2. Date of Death<br>Month Day Year<br>JULY 17, 1996  |  | 3. Time of Death<br>7:50 PM.                                     |   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>JOHNS HOPKINS HOSPITAL   |   |   |   | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death  |   |   |
| Funeral<br>Director   | 5. Social Security Number<br>219 88 7198   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>20 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>11-16-75               | 9. Birthplace (State or Foreign Country)<br>Md    |   |
|   | Usual Residence of Decedent  |   |   |   | 10e. State<br>Md   |  | 10b. County<br>N.A.  | 10c. City, Town or Location<br>Balto.             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br>324 E. Biddle ST   |   | 10f. Zip Code<br>21202  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |   |   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |   |   |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12):<br>12 <sup>th</sup> Grade   |   | College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Katorer  |  | 16b. Kind of Business/Industry<br>contractor                     |   |   |
|   | 17. Father's Name (First, Middle, Last)<br>PAUL LEE  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>PATRICIA JOHNSON  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Phyllis LEE  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>324 E. Biddle ST. Balto. Md. 21202  |  |  |   |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt Zion Cem.  |   | Date<br>7/25/96  |  | 20c. Location - City or Town, State<br>LanDowns. Md              |   |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Joseph B. Locks</i>  |   |   |   | 22. Name and Address of Facility<br>Locks Funeral Home 1304 N. Central Ave   |  |  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Multiple gun shot wounds.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |   | Approximate Interval Between Onset and Death   |  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |   |
|   |  |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)<br>7-17-96  |   | 28b. Time of Injury<br>1929 M             |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>subject shot |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>1100 BLK Barkley St   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Street   |  |   |   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br>O.C.M.E.           |  | 29d. Date signed (Month, Day, Year)<br>JULY 18, 1996   |  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David R Fowler 111 Penn Street, Baltimore, Maryland 21201   |  |   |   |   |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1996  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |   |  |  |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

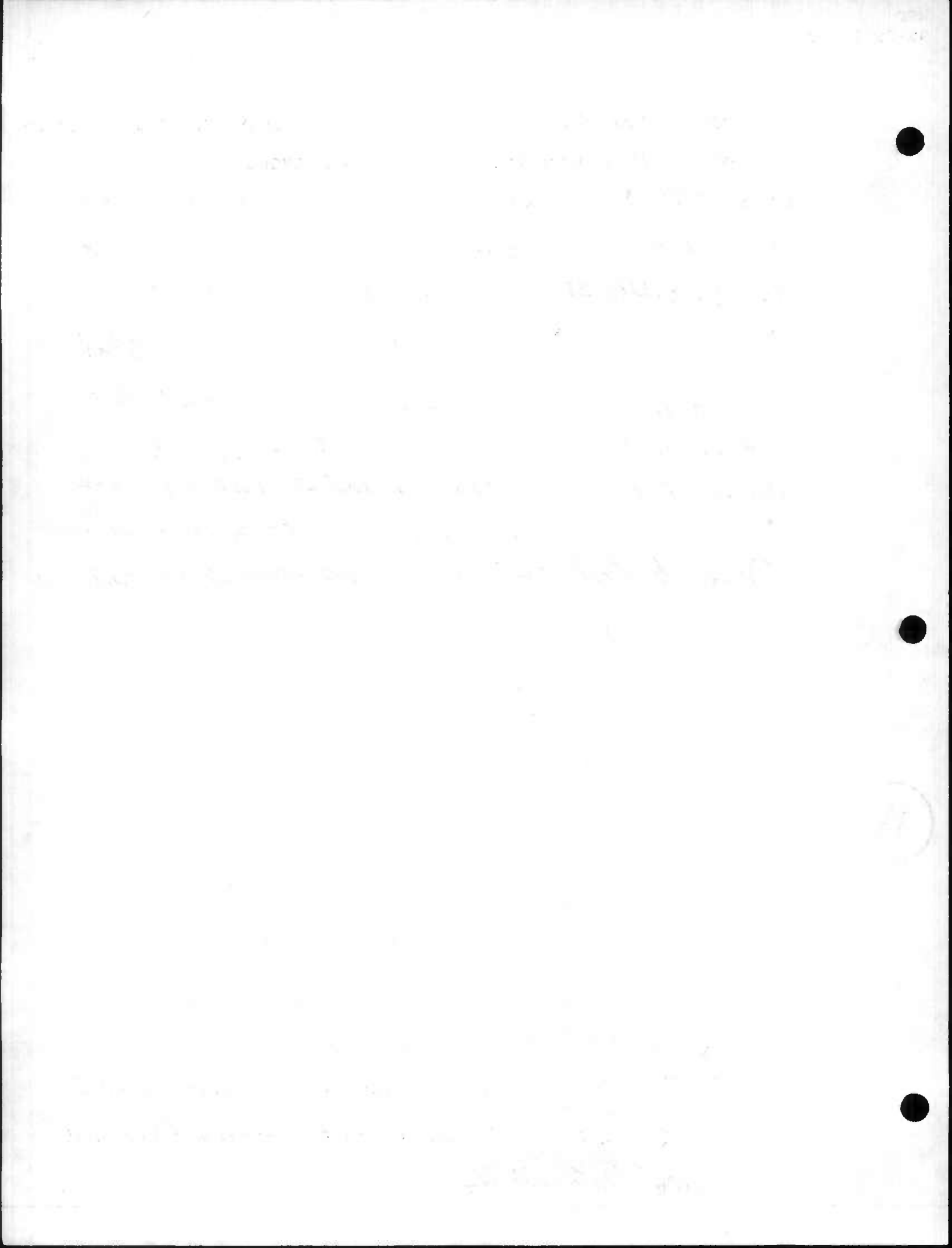
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

21803

## Certificate of Death

Reg. No.

|  |  |  |                                 |  |  |  |   |   |   |   |  |
|--|--|--|---------------------------------|--|--|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Frank Junior Lamb</b>                       |  |                                 |  | 2. Date of Death<br>Month Day Year<br><b>July 20, 1996</b> |  |   |   | 3. Time of Death<br><b>8:15 PM</b>                      |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>4420 Woodlea Ave.</b> |  |                                 |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |   |   | 4c. County of Death<br><b>N/A</b>                       |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-36-6555</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F |  | 7. Age (in yrs. last birthday)<br><b>58</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 13, 1937</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b> |   |  |
|  | Usual Residence of Decedent  |  |                                 |  |  |  |   |   |   |   |  |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>N/A</b>  |                                 | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   |   |  |
| 10e. Street and Number<br><b>4420 Woodlea Ave.</b>   |  |  |                                 | 10f. Zip Code<br><b>21206</b>  |  |  |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4or 5+)   |  |  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                   |  |  |   | 16b. Kind of Business/Industry<br><b>Paper Goods</b>  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jesse Lamb</b>   |  |  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maude Banks</b>  |  |  |   |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Lou Lamb Wife</b>   |  |  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4420 Woodlea Ave. Baltimore, Md. 21206</b>     |  |  |   |   |   |   |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |                                 | Data<br><b>7-24</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore</b>                      |   |   |   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Anthony C. Connelly</i>  |  |  |                                 | 22. Name and Address of Facility<br><b>Connelly Funeral Home Of Dundalk<br/>7110 Sollers Point Rd. 21222</b>                                       |  |  |   |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Melanotic Lung Carcinoma</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |  |                                 |  |  |  |   |   |   | Approximate Interval Between Onset and Death<br><b>1 yr</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |                                 |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |   |  |
|  |  |  |                                 |  |  |  |   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |   |   |  |
|  |  |  |                                 |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No               |   |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 28. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |                                 |  |  |  |   |   |   |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |                                 | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                             |   | 28d. Describe how injury occurred   |   |   |  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |                                 |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |   |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><i>S. Olan</i>  |                                 |  |  | 29c. License number<br><b>D 30641</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>7/22/96</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Ramesh S. Sathiyamoorthy, MD. 201-109 BACKRIVER NECK RD BALTO. MD 21221</b>   |  |  |                                 |  |  |  |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |  |  |                                 |  |  |  |   |   |   |   |  |

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21804

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY LOGAN

2. Date of Death

Month

Day

Year

7

23

96

3. Time of Death

725PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-30-2938

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 1, 1899

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7704 Fairgreen Rd.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Stephen Fallon

18. Mother's Name (First, Middle, Maiden Surname)

Honour Loftus

19a. Informant's Name/Relationship (Type, Print)

Minerva R. Kuessner

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Daug. 1805 Jackson Rd. Dundalk, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Stanislaus Cem.

Date

7-26

20c. Location - City or Town, State

Dundalk

21. Signature of Funeral Service Licensee

Anthony C. Connelly

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk  
7110 Sollers Point Rd. 2122223a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. PONTINE CVA  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 HOUR

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PROBABLE ALZHEIMERS TYPE DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Michael A. Ankram MD

29c. License number

046360

29d. Date signed (Month, Day, Year)

7/23/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MICHAEL A. ANKRAM MD 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE MD 21224

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

Wilson-Rendall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: This certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21805

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David W. Lang Jr.

2. Date of Death

Month July Day 16 Year 1996

3. Time of Death

12:30 A.M.

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

212 42 4272

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 4, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Millersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8361 Oakwood Road

10f. Zip Code

21108

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: Viet Nam

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Stockman

16b. Kind of Business/Industry

General Motors

17. Father's Name (First, Middle, Last)

David W. Lang Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Adeline Schaffner

19a. Informant's Name/Relationship (Type, Print)

Betty Lang

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8361 Oakwood Road Millersville, Maryland 21108

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

7/19/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Richard Gomez

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Lung Cancer metastatic to 3 years

Due to (or as a consequence of):

b. Bone and Peritoneum

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mayer Gorbatsky M.D.

29c. License number

027938

29d. Date signed (Month, Day, Year)

7/16/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mayer Gorbatsky M.D. 795 Aqueduct Rd. Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

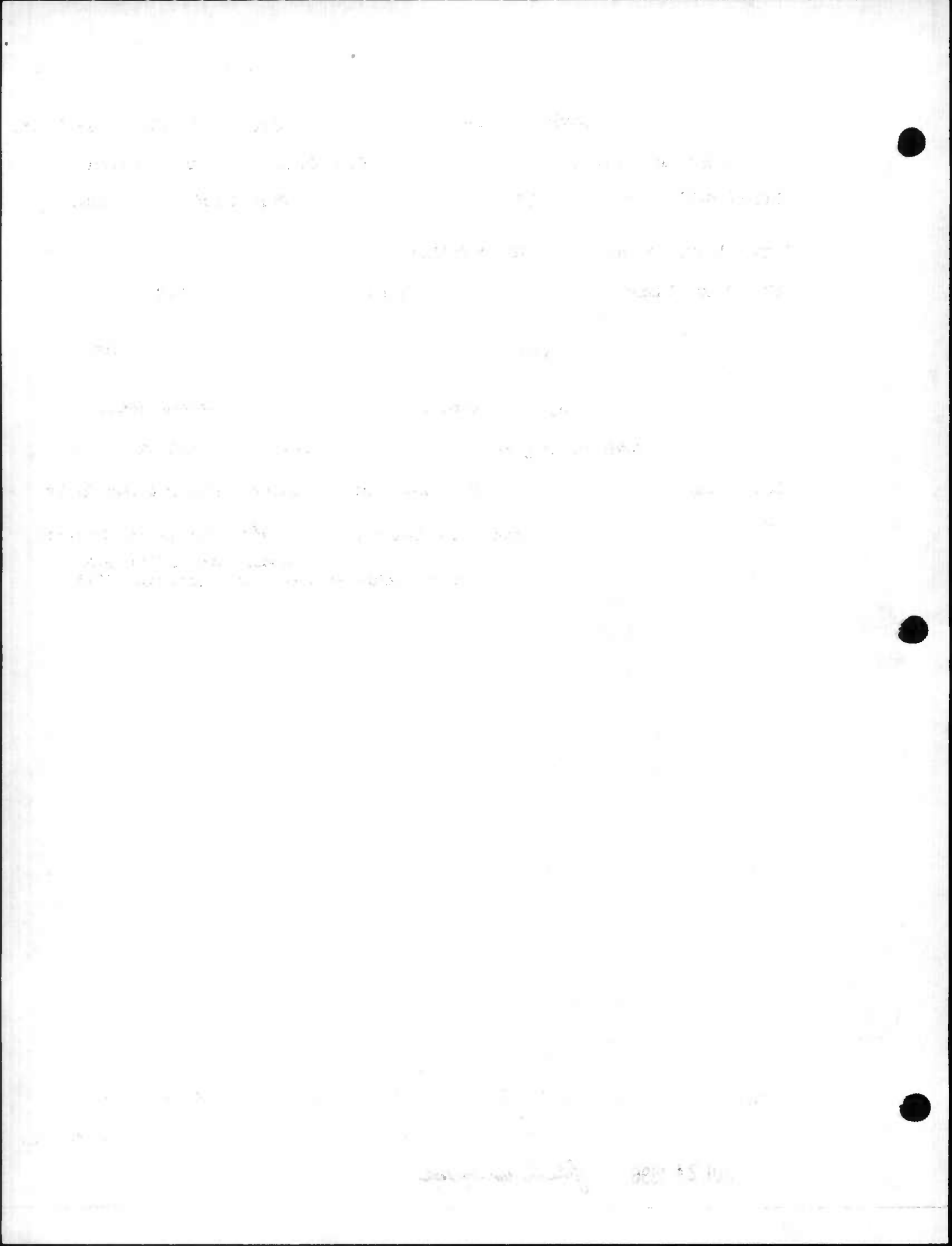
Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours of death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled out by the funeral director, page 2 should be detached for use as the burial-transit  
document.

Medical Certification: To Be Completed by Physician/Medical Examiner





96 21806

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Gloria Frances Levy</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 22, 1996</b>   |  | 3. TIME OF DEATH<br><b>5:51 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-10-7965</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 04, 1925</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore, Md.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1504 Melton Road</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Lutherville</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore Co.</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore Co.</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Lutherville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1504 Melton Road</b>  |  |
| 10f. ZIP CODE<br><b>21093</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Home Maker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lee Truitt</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Wertz</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Henry J. Levy (Husband)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1504 Melton Road Lutherville, Maryland 21093</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery 7/25/96 Baltimore, Maryland</b>   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Jeffrey L. Gair</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road Towson, Maryland 21204</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepatocellular Carcinoma</b><br>Approximate Interval Between Onset and Death <b>3 months</b><br>Due to (or as a consequence of):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  | 25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Seamus O'Reilly MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D46515</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 23rd 1996</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Seamus O'Reilly Johns Hopkins Oncology Center 600 N Wolfe St. Baltimore MD 21287</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 24 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 21807

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LIPSCOMB, BABY GIRL</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>05</b> DAY <b>29</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>4:03A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>unknown</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>&lt;1 YRS.</b>   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>MONTH <b>05</b> DAY <b>28</b> YEAR <b>96</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>MERCY HOSPITAL</b>  |  | 10. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD</b>   |  |
| 11. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |   |  | 12. RESIDENCE OF DECEDENT   |  | 13. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 14. STATE<br><b>MD</b>  |  | 15. COUNTY<br><b>n/a</b>  |  | 16. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  | 17. ZIP CODE<br><b>21206</b>  |  |
| 18. STREET AND NUMBER<br><b>4929 Goodnow Rd Apt F</b>   |  |   |  | 19. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 20. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |   |  | 22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 23. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |
| 24. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>0</b>  |  |   |  | 25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>n/a</b>   |  | 26. KIND OF BUSINESS/INDUSTRY<br><b>n/a</b>   |  |
| 27. FATHER'S NAME (First, Middle, Last)<br><b>unknown</b>   |  |   |  | 28. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CHURIES LIPSCOMB</b>  |  |   |  |
| 29. INFORMANT'S NAME (Type/Print)<br><b>Churies Lipscomb</b>  |  |   |  | 30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as above.</b>   |  |   |  |
| 31. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DATE</b>   |  | 33. LOCATION — City or Town, State  |  |
| 34. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ronald S. Wade, Dir.</b>  |  |   |  | 35. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board-655 W. Baltimore Street<br/>Baltimore, Maryland 21201-1559</b>   |  |   |  |
| 36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARRHYTHMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>RESPIRATORY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>EXTREME PREMATURITY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>20 MIN</b><br><b>8 HS</b><br><b>8 HS</b> |  |   |  |   |  |   |  |
| 37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEPSIS</b>   |  |   |  |   |  |   |  |
| 38. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  | 39. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 40. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                           |  |
| 41. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 42. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |   |  |
| 43. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 44. DATE OF INJURY (Month, Day, Year)   |  | 45. TIME OF INJURY<br><b>M</b>  |  | 46. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 47. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 48. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 49. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 50. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |
| 51. SIGNATURE AND TITLE OF CERTIFIER<br><b>Linda Pauliks MD</b>   |  | 52. LICENSE NUMBER<br><b>AG 2433059</b>   |  | 53. DATE SIGNED (Month, Day, Year)<br><b>5/29/96</b>  |  |   |  |
| 54. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Linda Pauliks, 22 S. GREENE ST., BALTIMORE, MD 21201</b>  |  |   |  |   |  |   |  |
| 55. DATE FILED (Month, Day, Year)<br><b>JUL 24 1996</b>   |  | 56. REGISTRAR'S SIGNATURE<br><b>John Swiden</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Supplemental

1944-1945

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21808

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel

McGahagan

2. Date of Death

July 19, 1996

3. Time of Death

10:15 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore County

5. Social Security Number

216 24 8954

8. Sex

10 M 20 F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 16, 1930

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

5028 Hilltop Acres Road

10f. Zip Code

21128

10g. Citizen of What Country?

U.S.

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No  
If Yes, Give Year or Dates: 1955-195713. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Fitter

16b. Kind of Business/Industry

Buffalo Tank

17. Father's Name (First, Middle, Last)

John F. McGahagan

18. Mother's Name (First, Middle, Maiden Surname)

Mary Petpushak

19a. Informant's Name/Relationship (Type, Print)

Mary T. Yeshnik

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

785 View West Drive Westminster, Maryland 21158

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley

Date

7/23/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

C. Richard Gonce

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Acute Myocardial Infarction

Approximate  
Interval Between  
Onset and Death

2 days

Due to (or as a consequence of):

b. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy  
performed?

10 Yes 20 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

10 Yes 20 No

25. Was case referred to medical  
examiner? X  
10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

40 Nursing Home 50 Residence 80 Other (Specify)

27. Manner of Death

10 Natural 50 Pending  
20 Accident 60 investigation  
30 Suicide 60 Could not be  
40 Homicide 60 determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

10 Yes 20 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

Howard Farrington

29c. License number

RD1897

29d. Date signed (Month, Day, Year)

7/19/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Farrington M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital of Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: This certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

6 + VA

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the transparency and accountability of the organization. This section also outlines the specific procedures for recording and verifying financial data.

2. The second part of the document addresses the role of the audit committee in overseeing the financial reporting process. It details the committee's responsibilities, including reviewing the financial statements, assessing the effectiveness of internal controls, and ensuring compliance with applicable laws and regulations. The committee is also responsible for reporting its findings to the board of directors.

3. The third part of the document focuses on the importance of internal controls in preventing fraud and errors. It describes the various types of controls, such as segregation of duties, authorization requirements, and reconciliation procedures, and explains how they are implemented within the organization. This section also discusses the role of management in establishing and maintaining a strong control environment.

4. The fourth part of the document discusses the importance of communication and collaboration in the financial reporting process. It emphasizes the need for clear communication between all levels of the organization, from management to the audit committee, to ensure that all relevant information is shared and understood. This section also outlines the specific communication channels and protocols that should be followed.

5. The fifth part of the document discusses the importance of ongoing monitoring and improvement of the financial reporting process. It emphasizes that the organization should regularly review and update its policies and procedures to reflect changes in the business environment and regulatory requirements. This section also discusses the role of the audit committee in monitoring the effectiveness of the financial reporting process and identifying areas for improvement.

6. The sixth part of the document discusses the importance of training and education for all employees involved in the financial reporting process. It emphasizes that all employees should have a clear understanding of their roles and responsibilities and should be equipped with the necessary skills and knowledge to perform their duties effectively. This section also outlines the specific training and education programs that should be implemented.

7. The seventh part of the document discusses the importance of external audits in providing an independent assessment of the organization's financial statements. It emphasizes that external audits are essential for ensuring the reliability and accuracy of the financial information and for providing assurance to investors and other stakeholders. This section also outlines the specific requirements for external audits and the role of the audit committee in selecting and overseeing the external auditor.

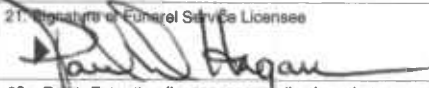
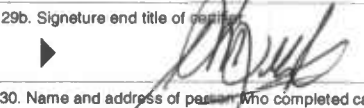

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21809

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Agnes M. Mensing</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>July 20 1996</b>   |  | 3. Time of Death<br><b>1:30 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Summit Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Caltonsville</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-80-5940</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 2, 1911</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>4626 Coleherne Road</b>  |  | 10f. Zip Code<br><b>21229</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |  | 16b. Kind of Business/Industry<br><b>own home</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>William P. Davis</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Buckley</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Agnes Brittingham, daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2407 Christian Street Baltimore, MD 21223</b>   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>7/23 Baltimore, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Ambrose Funeral Home, Inc. Arbutus<br/>1328 Sulphur Spring Road 21227</b>   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CHF</b><br>Due to (or as a consequence of):<br><b>b. Dementia</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>56 hrs.</b><br><b>248</b>  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
|   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
|   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 26294</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/22/96</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Luis M. Zuniga 1101 Maiden Choice Lane Baltimore, Maryland 21227</b>  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |  | 32. Registrar's Signature<br>                                      |  |   |  |  |  |
|   |   |  |   |  |   |  |  |  |

11-11-11

Dear Sir,  
I have the pleasure to acknowledge the receipt of your letter of the 11th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours faithfully,

Wm. H. H. H.

I am, Sir, very respectfully,  
Yours faithfully,  
Wm. H. H. H.

Wm. H. H. H.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21810

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |   |  |   |  |
|---|---|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DARLENE MYERS</b>  |  |   |  | 2. Date of Death<br>Month <b>JULY</b> , Day <b>22</b> , Year <b>1996</b>   |   | 3. Time of Death<br><b>2:35 PM</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Church Home Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>n/a</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-42-5037</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>53</b> Yrs.                             | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>2/9/1943</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |  |
|   | Usual Residence of Decedent   |  |   |  |  |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>3515 Gough Street</b>  |  |   |  | 10f. Zip Code<br><b>21224</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home maker</b>   |   | 16b. Kind of Business/Industry<br><b>In Own Home</b>   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harvey Woodring</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn Woodring</b>  |   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print) <b>spouse</b><br><b>Arthur Myers</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3515 Gough Street Baltimore, Md. 21224</b>   |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Rosary Cemetery</b>   |  | Date<br><b>7/25/96</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>                                   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Marie A. Zannino</b>  |  |   |  | 22. Name and Address of Facility<br><b>Joseph N. Zannino Jr. F.H.<br/>263 S. Conkling St. BALTIMORE, Md. 21224</b>   |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>METASTATIC CANCER OF LUNG</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>WEEKS</b> |  |   |  |  |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |  |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                               |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>A. R. Nazemi</b>  |   |  |   | 29c. License number<br><b>D17322</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY, 22, 1996</b>                                |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A. R. NAZEMI, M.D. - CHURCH HOSPITAL, BALT. MD.</b>  |   |  |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |   |  |   | 32. Registrar's Signature<br><b>[Signature]</b>                              |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 21811

Reg. No.

|  |   |  |   |   |  |   |  |  |  |  |
|--|---|--|---|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>BERTRAM HENRY MORALES   |  |   |   | 2. Date of Death<br>Month JULY Day 21 Year 1996  |   | 3. Time of Death<br>3:45 AM  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>SHOCK TRAUMA CENTER   |  |   |   | 4b. City, Town, or Location of Death<br>BALTIMORE  |   | 4c. County of Death<br>N/A   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>218-14-0064  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>70 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>8-15-1925   |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent   |  |   |   |  |   |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>Maryland  |  | 10b. County<br>Baltimore  |   | 10c. City, Town or Location<br>Baldwin   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|  | 10e. Street and Number<br>4455 Carroll Manor Road   |  |   |   | 10f. Zip Code<br>21013   |   | 10g. Citizen of What Country?<br>U. S. A.  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Asst. Secretary  |   |  | 16b. Kind of Business/Industry<br>Monumental Life Ins. Co.  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Henran Morales   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Aida Williams   |   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Jane Morales (Wife)   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4455 Carroll Manor Road, Baldwin, Md. 21013   |   |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Highview Cemetery   |   | Date<br>7-24-96  |   | 20c. Location - City or Town, State<br>Fallston, Maryland  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Wallace S. Brooks Jr.  |  |   |   | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Road, Towson, Md. 21204  |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Multiple injuries with complications<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|  |   |  |   |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br>7 4 96  |   | 28b. Time of Injury<br>9:53 AM   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>CAR DRIVEN OFF CAR STRUCK BY  |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>RWOOD WAY   |   |  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>JANETINUE PKY, BALTIMORE, MD |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>Henry Morales  |   | 29c. License number<br>O.C.M.E.  |   | 29d. Date signed (Month, Day, Year)<br>JULY 22, 1996   |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>MARLENE A. LORAN 111 Penn Street, Baltimore, Maryland 21201   |  |   |   |  |   |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>JUL 24 1996  |  |   |   | 32. Registrar's Signature<br>[Signature]   |   |  |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10/1  
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21812

|  |  |  |   |  |   |   |  |  |
|--|--|--|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT THOMAS Point</b>   |  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>19</b> Year <b>1996</b> |   | 3. Time of Death<br><b>8:30PM</b>       |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>2118 EASTHAM ROAD</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Timonium</b>              |   | 4c. County of Death<br><b>BALTIMORE</b> |  |  |
| Funeral<br>Director                              | 5. Social Security Number<br><b>195-14-7867</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 19, 1922</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>  |  | 10e. State<br><b>MARLAND</b>  |  | 10b. County<br><b>BALTIMORE</b>   |   | 10c. City, Town or Location<br><b>Timonium</b>   |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>2118 EASTHAM ROAD</b>  |  | 10f. Zip Code<br><b>21093</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>W.W.II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12YRS.</b> College (1-4 or 5+) <b>4YRS.</b>  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PHYSICIANS ASS'T.</b>                            |  | 16b. Kind of Business/Industry<br><b>BETHLEHEM STEEL</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>FRANK Point</b>  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY NORRIS</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Josephine Point</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2118 EASTHAM ROAD Timonium MARYLAND 21093</b>   |   | 20. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |
| To Be Completed by<br>Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OUR LADY VALLEY MEMORIAL</b>  |  | 20c. Location - City or Town, State<br><b>Timonium, MARYLAND</b>  |  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>   |   | 22. Name and Address of Facility<br><b>EVANS CHAPEL OF CHIMES<br/>2325 YORK ROAD - Timonium</b>  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Metastatic GASTRIC CANCER</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>MONTHS</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by<br>Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide |  |
|  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
| To Be Completed by<br>Physician/Medical Examiner | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>A Syon</b>   |  |
|  | 29c. License number<br><b>037362</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 22, 1996</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. ANTHONY SARAFIS - 1205 YORK ROAD - LUTHERVILLE</b>   |   | 31. Date of Death<br><b>JUL 24 1996</b>  |  |

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is well-posed and that the solution exists and is unique.

2. In the second part, the author considers the case of a specific problem. It is shown that the solution can be obtained by using the method of characteristics.

3. The third part of the paper is devoted to a numerical analysis of the problem. It is shown that the numerical solution is stable and convergent.

4. Finally, the author discusses the results of the paper and gives some conclusions. It is shown that the problem is well-posed and that the solution exists and is unique.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21813

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |  |  |
|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JEAN THERESA PAWLISKE</b>                        |   |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>21</b> Year <b>1996</b> |  | 3. Time of Death<br><b>3PM.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>             |  | 4c. County of Death<br><b>BALTIMORE CITY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>196 22 9160</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 6. Date of Birth (Month, Day, Year)<br><b>Oct. 3, 1929</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |
|  | Usual Residence of Decedent   |   |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>300 Hillcrest Avenue</b>  |   |   |  | 10f. Zip Code<br><b>21225</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>  |  | 16b. Kind of Business/Industry<br><b>M.V.A. St. of Maryland</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Sullivan</b>   |   |   |  | 16. Mother's Name (First, Middle, Maiden Surname)<br><b>Aline Dillon</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert F. Pawliske</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>300 Hillcrest Avenue Baltimore, Maryland 21225</b>                                       |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  | Date<br><b>7/25/96</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Jerome Gronowicz</i>   |   |   |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>   |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. STROKE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. BILATERAL CAROTID STENOSIS</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d. |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>3 days.</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>CC C S MD.</b>   |   |   |  | 29c. License number<br><b>D24076</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 21, 1996</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHUNG C Ng. MD.<br/>HARBOR HOSPITAL CENTER 300 S HARVOR ST. BALTIMORE, MD 21225</b>   |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |   |   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21814

Certificate of Death

Reg. No.

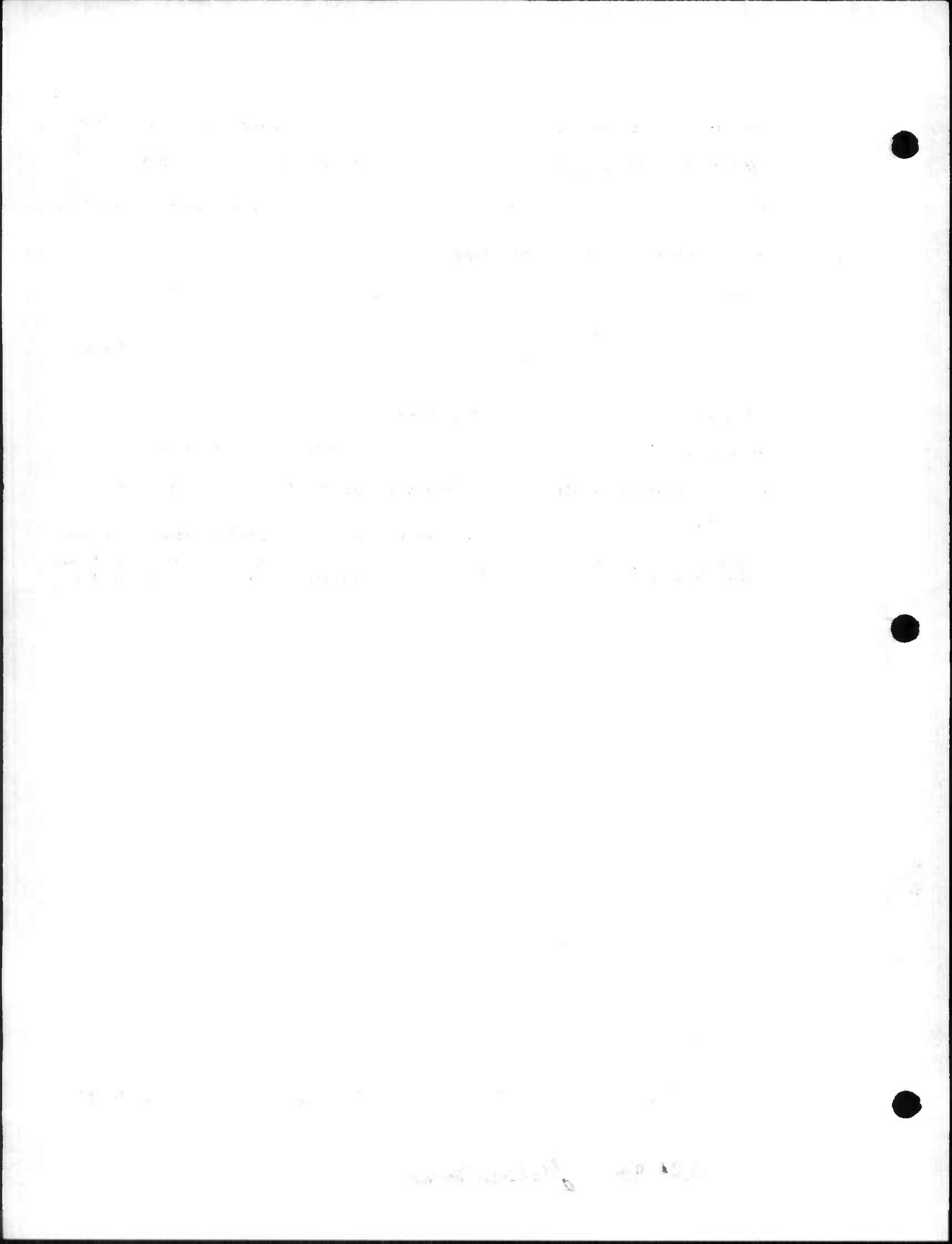
|   |  |   |   |   |   |  |  |  |   |
|---|--|---|---|---|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Herbert O. Pierson Jr.   |   |   |   |   | 2. Date of Death<br>Month Day Year<br>July 20, 1996                                  |  | 3. Time of Death<br>1:21 A.M.  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Harbor Hospital Center   |   |   |   |   | 4b. City, Town, or Location of Death<br>Baltimore                                    |  | 4c. County of Death<br>N/A   |   |
| Funeral<br>Director   | 5. Social Security Number<br>213-14-5121   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>74 Yrs. | If Under 1 Year<br>Montha Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>May 10, 1922                          |  | 9. Birthplace (State or Foreign Country)<br>Maryland                            |
|   | Usual Residence of Decedent  |   |   |   |   |  |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |   | 10b. County<br>Anne Arundel   |   | 10c. City, Town or Location<br>Baltimore  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
|   | 10e. Street and Number<br>4400 4th Street  |   |   |   | 10f. Zip Code<br>21225  |  | 10g. Citizen of What Country?<br>U.S.A.                                      |  |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th Grade<br>College (1-4or 5+) College (1-4or 5+)  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Longshoreman   |  |  | 16b. Kind of Business/Industry<br>Shipping   |   |
|   | 17. Father's Name (First, Middle, Last)<br>Herbert O. Pierson  |   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Myra L. Gardener                |  |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Betty E. Pierson - Wife  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4400 4th Street Baltimore, Maryland 21225  |  |  |  |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory Inc   |   | Date<br>7/22/96   |  | 20c. Location - City or Town, State<br>Baltimore Maryland                    |  |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Richard E. Davis</i>   |   |   |   | 22. Name and Address of Facility<br>George J. Gonce Funeral Home<br>4001 Ritchie Highway Baltimore Maryland 21225   |  |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>CARDIAC ARREST</u><br>Due to (or as a consequence of):<br>b. <u>A.S.C.V.D</u><br>Due to (or as a consequence of):<br>c. <u>HYPERTENSION</u><br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |   |   |  |  |  | Approximate Interval Between Onset and Death<br>10 mins<br>20 YRS -<br>20 YRS - |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>PERIPHERAL VASCULAR DISEASE.</u><br><u>GERD. POLIO.</u>   |   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Richard E. Davis</i>  |   | 29c. License number<br>D17753             |   | 29d. Date signed (Month, Day, Year)<br>7-22-96                                       |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. K. Dharmasena 710 Church Street Baltimore, Maryland 21225   |  |   |   |   |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1996  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |   |   |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit



asp

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21815

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner1. Decedent's Name (First, Middle, Last)  
JOHN

PAOLUCCI

2. Date of Death  
Month Day Year  
JULY 22 19963. Time of Death  
9:10 PFuneral  
Director4e. Facility Name (If not institution, give street and number)  
3114 HILLTOP AVE4b. City, Town, or Location of Death  
BALTIMORE4c. County of Death  
BALTIMORE5. Social Security Number  
097-48-55596. Sex  
☒ M ☐ F7. Age (In yrs. last birthday)  
41 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
SEPT. 1, 19549. Birthplace (State or Foreign  
Country)  
ITALY

Usual Residence of Decedent

10a. State  
MARYLAND10b. County  
BALTIMORE10c. City, Town or Location  
BALTIMORE10d. Inside City Limits  
☐ Yes ☒ No

10e. Street and Number

3114 HILLTOP AVENUE

10f. Zip Code

21227

10g. Citizen of What Country?

ITALY

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced12. Was Decedent Ever In U.S.  
Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CHEF / MANAGER

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

DONATO PAOLUCCI

18. Mother's Name (First, Middle, Maiden Surname)

ASSUNTA IAMARINO

19a. Informant's Name/Relationship (Type, Print)

DIANE PAOLUCCI / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6639 WAGON DRIVE, FREDERICKSBURG, VIRGINIA 22407

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date  
JULY 25,  
1996

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Anthony J. DiMuzio

22. Name and Address of Facility

LOUDON PARK FUNERAL HOME

3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?  
partial☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dennis J. Chute MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 23, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examinerto the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
to the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



96 21816

item #24a, 29d, filing 737, 7/24/96, cyw, per DR.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Solomon Lloyd Purdie</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>July 14 1996</i>   |  | 3. TIME OF DEATH<br><i>0134 A M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>240-10-7739</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>91</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>May 12, 1905</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>N. Carolina</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Deaton Nursing Home</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>  |  |
| 9c. COUNTY OF DEATH<br><i>N/A</i>  |  |  |  | 10a. STATE<br><i>MD</i>   |  | 10b. COUNTY<br><i>N/A</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>BALTIMORE</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>834 WHITMORE AVENUE</i>   |  |
| 10f. ZIP CODE<br><i>21216</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Black</i>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8th</i> College (1-4 or 5+) <i>College (1-4 or 5+)</i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Stevedore</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Steel</i>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>James Purdie</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Irene Purdie</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Dora Purdie/wife</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>834 Whitmore Avenue, Balto., MD 21216</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>King Memorial Park 7/19 Randallstown, MD</i>  |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE 21207</i>  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration pneumonia</i>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. <i>Multiple infected wounds</i>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. <i>Diabetes mellitus</i>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d.   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |  |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>C. M. H. H. H.</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D34974</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>JULY 15, 1996</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>5865 Robert Oliver place #121, Columbia, MD 21045</i>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>JUL 24 1996</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21817

Reg. No.

|  |  |   |   |                                     |   |   |  |  |
|--|--|---|---|-------------------------------------|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>JANE R PRIMER</u>   |   |   |                                     | 2. Date of Death<br>Month <u>July</u> Day <u>21</u> Year <u>96</u>  |   | 3. Time of Death<br><u>2:55 PM</u>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Anne Arundel General</u>  |   |   |                                     | 4b. City, Town, or Location of Death<br><u>Annapolis</u>  |   | 4c. County of Death<br><u>Anne Arundel</u>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>331-18-3647</u>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                     | 7. Age (In yrs. last birthday)<br><u>83</u> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><u>Oct. 26, 1912</u>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><u>Illinois</u>  |   | 10a. State<br><u>Maryland</u>   |                                     | 10b. County<br><u>Anne Arundel</u>  |   | 10c. City, Town or Location<br><u>Annapolis</u>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><u>570 Bellerive Drive</u>  |                                     | 10f. Zip Code<br><u>21401</u>   |   | 10g. Citizen of What Country?<br><u>USA</u>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> Collega (1-4or 5+) <u></u>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Clerk</u>                             |                                     | 16b. Kind of Business/Industry<br><u>Library</u>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><u>Unknown</u>  |   |   |                                     | 18. Mother's Name (First, Middle, Maiden Summa)<br><u>Unknown Richardson</u>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Bonnie L. Baker/Personal Rep.</u>   |   |   |                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7635 Paradise Beach Road, Pasadena, MD 21122</u>  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>MetroCrematory, Inc.</u>   |                                     | 20c. Location - City or Town, State<br><u>Baltimore, Maryland</u>   |   | 20d. Date<br><u>Jul.24</u>   |  |
|  | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>  |   |   |                                     | 22. Name and Address of Facility<br><u>Stallings Funeral Home, P.A.<br/>3111 Mountain Road, Pasadena, MD 21122</u>  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Causa (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <u>Hypovolemic Shock</u><br>Due to (or as a consequence of):<br><br>b. <u>Sepsis</u><br>Due to (or as a consequence of):<br><br>c. <u>Urinary Tract Infection</u><br>Due to (or as a consequence of):<br><br>d. <u></u> |   |   |                                     |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |                                     |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |   |                                     |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |   |                                     |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                     |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><u>M</u>     |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |   |                                     |   |   |  |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                     |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><u>[Signature]</u>   |   | 29c. License number<br><u>20357</u> |   | 29d. Date signed (Month, Day, Year)<br><u>7-21-96</u>   |  |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><u>Anthony Caputo, M.D., 139 Old Solomons Island Road, Annapolis, MD 21401</u>   |  |   |   |                                     |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 24 1996</u>  |  | 32. Registrar's Signature<br><u>[Signature]</u>   |   |                                     |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21818

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD GEORGE ROLLER

2. Date of Death  
Month Day Year

JULY 20 1996

3. Time of Death

0015

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

220-07-3492

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

JUNE 25, 1919

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

MARYLAND Line

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

812 OLD HARRIS MILL ROAD

10f. Zip Code

21105

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12YRS.

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

FIREMAN

16b. Kind of Business/Industry

BALTIMORE COUNTY FIRE DEPARTMENT

17. Father's Name (First, Middle, Last)

CHARLES ROY ROLLER

18. Mother's Name (First, Middle, Maiden Surname)

ROSIE B. MAYLOR

19a. Informant's Name/Relationship (Type, Print)

BARBARA R. BAGLEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

R.O.#4 BOX 4434 GLEN ROCK, PENNSYLVANIA 17327

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OULANSKY VALLEY MEMORIAL

Date

JULY 24

20c. Location - City or Town, State

TIMONIUM, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS CHAPEL OF CHIMES  
2325 YORK ROAD - TIMONIUM

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MINUTES

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D19155

29d. Date signed (Month, Day, Year)

7/22/96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARK S. KAPLAN M.D. 1694 YORK RD MONKTON MD 21111

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21819

Reg. No.

|   |  |  |   |   |  |                          |   |  |  |   |  |  |  |
|---|--|--|---|---|--|--------------------------|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>William R. Rutkowski   |  |   |   | 2. Date of Death<br>Month Day Year<br>July 20, 1996  |                          |   |  | 3. Time of Death<br>12 45 PM   |   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>6821 Boston Ave.   |  |   |   | 4b. City, Town, or Location of Death<br>Dundalk  |                          |   |  | 4c. County of Death<br>Baltimore   |   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-09-5668   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>75 Yrs.  |                          | 8. Date of Birth (Month, Day, Year)<br>Feb. 1, 1921 |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |   |  |  |  |
|   | Usual Residence of Decedent  |  |   |   |  |                          |   |  |  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Md.  |  | 10b. County<br>Baltimore  |   | 10c. City, Town or Location<br>Dundalk   |                          |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |  |  |
|   | 10e. Street and Number<br>6821 Boston Ave.   |  |   |   | 10f. Zip Code<br>21222   |                          |   |  | 10g. Citizen of What Country?<br>USA   |   |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                          |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 yrs. College (1-4or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Tool & Dye Maker  |                          |   |  | 16b. Kind of Business/Industry<br>Martin-Marietta  |   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Anthony Rutkowski   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ida Bujanowski  |                          |   |  |  |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Genevieve Rutkowski  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6821 Boston Ave. Dundalk, Md. 21222   |                          |   |  |  |   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sacred Heart of Mary   |                          |   |  | Date<br>7-23   |   | 20c. Location - City or Town, State<br>Dundalk |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Anthony Cdt Connolly</i>   |  |   |   | 22. Name and Address of Facility<br>Connolly Funeral Home Of Dundalk<br>7110 Sollers Ppoint Rd. 21222  |                          |   |  |  |   |  |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                    |  |   |   |  |                          |   |  |  |   |  |  |  |
|   | Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)<br>e. <u>MALIGNANT SARCOMA</u><br>Due to (or as a consequence of): |   |   |  |                          |   |  |  | Approximate Interval Between Onset and Death<br>15 MONTHS |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |  |   | b. Due to (or as a consequence of):   |  |                          |   |  |  |   |  |  |  |
|   |  |  |   | c. Due to (or as a consequence of):   |  |                          |   |  |  |   |  |  |  |
|   |  |  |   | d. Due to (or as a consequence of):   |  |                          |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  |                          |   |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   |   |  |                          |   |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |   |  |                          |   |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |   |  |                          |   |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |   |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                         |  |  |  |
|   |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   | 29b. Signature and title of certifier<br><i>B Douglas Smith</i>   |  |                          |   | 29c. License number<br>D 47398   |  | 29d. Date signed (Month, Day, Year)<br>JULY 22, 1996      |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>B. DOUGLAS SMITH 600 N. WOLFE ST. BALTO. MD 21287   |  |  |   |   |  |                          |   |  |  |   |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>JUL 24 1996   |  |   |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |                          |   |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

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Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21820

|  |  |   |   |                               |   |  |  |  |
|--|--|---|---|-------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>JOHN J. RODDOWSKY  |   |   |                               | 2. Date of Death<br>Month Day Year<br>JULY 20, 1996   |  | 3. Time of Death<br>2:00 am                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>5629 GUNPOWDER ROAD  |   |   |                               | 4b. City, Town, or Location of Death<br>WHITE MARSH   |  | 4c. County of Death<br>BALTIMORE                                 |  |
| Funeral<br>Director  | 5. Social Security Number<br>218148294   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |                               | 7. Age (In yrs. last birthday)<br>72 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>SEPT 11, 1923             |  |
|  | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |   | 10a. State<br>MD  |                               | 10b. County<br>BALTIMORE  |  | 10c. City, Town or Location<br>WHITE MARSH                       |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   |   |                               | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  | 10e. Street and Number<br>5629 GUNPOWDER ROAD  |   |   |                               | 10f. Zip Code<br>21162  |  | 10g. Citizen of What Country?<br>USA                             |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>TEACHING                                 |                               | 16b. Kind of Business/Industry<br>EDUCATION   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>JOHN J. RODDOWSKY SR.   |   |   |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>JOSEPHINE ZELENKA  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>JOAN M. RODDOWSKY/WIFE   |   |   |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5629 GUNPOWDER ROAD WHITE MARSH MD 21162   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>METRO CREMATORY   |                               | 20c. Date<br>7/22/96  |  | 20d. Location - City or Town, State<br>BALTIMORE, MD             |  |
|  | 21. Signature of Funeral Service Licensee  |   |   |                               | 22. Name and Address of Facility<br>CVACH/ROSEDALE FUNERAL HOME<br>1211 CHESACO AVE 21237   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |                               |   |  |  |  |
|  | <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Carcinoma of esophagus with metastases 2 yrs</p> <p>Due to (or as a consequence of):</p> <p>b. Diabetes mellitus yrs</p> <p>Due to (or as a consequence of):</p> <p>c. Hypertension yrs</p> <p>Due to (or as a consequence of):</p> <p>d. Kidney failure 2 yrs</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> |   |   |                               |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |                               |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |  |   |   |                               |   | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |  |   |   |                               |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                               |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br>07  |   | 28b. Time of Injury<br>M      |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
|  |  | 28d. Describe how injury occurred   |   |                               |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>Phyllis K. Pullen MD   |   | 29c. License number<br>D09620 |   | 29d. Date signed (Month, Day, Year)<br>07/20/1996  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Phyllis K. Pullen MD 2807 Jerusalem Rd Kingsville Md 21087   |  |   |   |                               |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1996   |  | 32. Registrar's Signature<br>John Davidson-Randall  |   |                               |   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

96 21821

Certificate of Death

Reg. No.

|  |  |                           |   |  |  |  |   |  |
|--|--|---------------------------|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Calvin Roy</b>                                      |                           |   |  | 2. Date of Death<br>Month Day Year<br><b>July 18, 1996</b>   |  | 3. Time of Death<br><b>10:30 AM</b>   |  |
|  | 4e. Facility Name (If not Institution, give street and number)<br><b>Northwest Hospital Center</b> |                           |   |  | 4b. City, Town, or Location of Death<br><b>Randallstown, Md</b>  |  | 4c. County of Death<br><b>Baltimore Co.</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-12-0186</b>  |                           | 6. Sex<br><b>1 M 2 F</b>  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>March 3, 1924</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>VA.</b>   |
|  | Usual Residence of Decedent  |                           |   |  |  |  |   |  |
| 10e. State<br><b>MD.</b>   |  | 10b. County<br><b>N/A</b> |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  | 10d. Inside City Limits<br><b>XX</b> Yes <input type="checkbox"/> No                        |  |
| 10e. Street and Number<br><b>124 W. FRANKLIN ST. APT#1413</b>  |  |                           |   | 10f. Zip Code<br><b>21201</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>-0-</b>   |  |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PLUMMER</b>                  |  | 16b. Kind of Business/Industry<br><b>HOME IMPROVEMENT</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>BOB YOUSE</b>  |  |                           |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HERBERT HAWKINS</b>   |  |                           |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3700 CLIFMAR Rd. BALTIMORE MD. 21244</b> |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARKCEM</b>  |  | Date<br><b>7/23/96</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE MD.</b>                                 |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> CFSP#281   |  |                           |   | 22. Name and Address of Facility<br><b>E.L. PHILLIPS FUNERL HOME</b><br><b>1721-1727 N. MONROE ST. BALTI. MD. 21217</b>                      |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. DIABETES</b><br>Due to (or as a consequence of):<br><b>b. HYPERTENSION</b><br>Due to (or as a consequence of):<br><b>c. Transient ischaemic attack</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                           |   |  |  |  |   | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Peripheral vascular disease</b>   |  |                           |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |  |                           |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                           | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |                           | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  |  |                           | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28d. Describe how injury occurred  |   |  |
|  |  |                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                           |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |                           |   | 29c. License number<br><b>D 31464</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/19/96</b>  |   |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>SHOAH A - HASTON MD 821 N. EUTAW ST Suite 308, Balt.</b>  |  |                           |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |  |                           | 32. Registrar's Signature<br><i>[Signature]</i> MD 21407  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760





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State of Maryland / Department of Health and Mental Hygiene

96 21822

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |   |  |   |
|---|--|--|--|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLOTTE SCHWARTZ TRAUER</b>   |  |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>16</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>07 35 AM</b>  |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-12-4794</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 16, 1926</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent  |  |  |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>  |   |
| To Be Completed by Funeral Director   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>2913 N. Rolling Road</b>  |   |
|   | 10f. Zip Code<br><b>21244</b>  |  |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
|   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>teller</b>   |   | 16b. Kind of Business/Industry<br><b>banking</b>   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>William S. Norfolk</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ella M. Fitzgerald</b>   |   |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Grace Stultz, daughter</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2760 Yarnall Road Baltimore, Maryland 21227</b>  |   |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland National</b>   |   | 20c. Location - City or Town, State<br><b>7/19/96 Laurel, Maryland</b>   |   |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Ambrose Funeral Home of Lansdowne<br/>2719 Hammonds Ferry Road 21227</b>  |   |  |   |
|   | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Immediate Cause (Final disease or condition resulting in death)</b><br>e. <b>METASTATIC CARCINOMA OF COLON</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |   |  |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |  |  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PNEUMONIA</b>  |  |  |  |  |  |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |   |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |  |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>                             |  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 28d. Describe how Injury occurred  |  |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                     |  |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |  |   |  |   |
| 29b. Signature and title of certifier<br><b>C. Ravi MD</b>  |  |  |  | 29c. License number<br><b>D37333</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 16, 1996</b> |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>C. RAVI MD, NHC, BALTIMORE MD 21133</b>  |  |  |  |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |  |  |  | 32. Registrar's Signature<br> |  |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

96 21823

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |  |   |
|---|---|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARY V. SHIPMAN</b>                                  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 22, 1996</b> |  | 3. Time of Death<br><b>6:57 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CATON MANOR NURSING CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-16-8693</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.   | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 28, 1902</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |   |
| 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>2015 GRINNALDS AVENUE</b>  |   |   |  | 10f. Zip Code<br><b>21230</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>JOHN WOLF</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MOLLY COOK</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY BIDEN / DAUGHTER</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>114 MINE BANK LANE, LANSDDOWNE, MARYLAND 21227</b>                                       |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEMETERY</b>   |  | Date<br><b>JULY 26, 1996</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |  | 22. Name and Address of Facility<br><b>LOUDON PARK FUNERAL HOME<br/>3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>MONTHS</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEHYDRATION</b><br><b>DEMENCIA</b>   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                             |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br><b>Surjit A. Julka MD</b>  |   |   |  | 29c. License number<br><b>D26 395</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/22/96</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>821 N. EUTAW ST. BALTIMORE MD 21201, SURJIT JULKA MD</b>   |   |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21824

Film G737 item 1 per FH 7-24-96 rja

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last) <u>Levi Shields, Sr.</u>                      |  |  |  |  |  | 2. Date of Death<br>Month <u>7</u> Day <u>18</u> Year <u>96</u>                                |  | 3. Time of Death<br><u>10:55</u>                                  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>V.A. HOSPITAL</u> |  |  |  |  |  | 4b. City, Town, or Location of Death<br><u>BALTIMORE</u>                                       |  | 4c. County of Death<br><u>BALTIMORE, CITY</u>                     |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>239-28-3396</u>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><u>75</u> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><u>4/12/1921</u>  |  | 9. Birthplace (State or Foreign Country)<br><u>NORTH CAROLINA</u> |  |  |
|   | 10a. State<br><u>MARYLAND</u>  |  | 10b. County<br><u>BALTIMORE, CITY</u>                                      |  | 10c. City, Town or Location<br><u>BALTIMORE</u>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |  |
| 10e. Street and Number<br><u>3004 LA RUE SQUARE E</u>   |  | 10f. Zip Code<br><u>21225</u>  |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>WW2</u><br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>LONGSHOREMAN</u> |  | 16b. Kind of Business/Industry<br><u>BETHLEHEM STEEL</u>   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u>  |  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>HENRY SHIELDS</u>   |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>SARAH GRIMES</u>   |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>LAURENA SHIELDS(WIFE)</u>  |  |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3004 LA RUE SQUARE E BALTIMORE, MARYLAND 21225</u>                         |  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>GARRISON FOREST CEMETERY 7/24/96 OWINGS MILLS, MARYLAND</u> |  |  |  | 20c. Location - City or Town, State  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>   |  |  |  | 22. Name and Address of Facility<br><u>ESTEP BROTHERS FUNERAL HOME PA.<br/>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217</u>                |  |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |  |  |  |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Cardio / Respiratory Distress</u><br>Due to (or as a consequence of):<br>b. <u>Adenocarcinoma of Lung</u><br>Due to (or as a consequence of):<br>c. <u>Abdominal Aortic Aneurysm</u><br>Due to (or as a consequence of):<br>d. |  |  |  |  |  |  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)             |  |  |  |  |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. Signature and title of certifier<br><u>[Signature]</u>  |  |  |  | 29c. License number<br><u>P08663</u>   |   | 29d. Date signed (Month, Day, Year)<br><u>7/18/96</u>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>Royce Fagan, MD BUAMC 1016 Green St Baltimore, MD 21201</u>  |  |  |  |  |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 24 1996</u>   |  |  |  | 32. Registrar's Signature<br><u>[Signature]</u>  |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours of death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96-3980-003

ITEMS: 23 PART I, 27, PER MEO  
FILM G-738 8/15/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21825

## Certificate of Death

Reg. No.

|   |   |  |   |                                |  |  |   |   |
|---|---|--|---|--------------------------------|--|--|---|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>PATRICIA SMITH</b>   |  |   |                                | 2. Date of Death<br>Month <b>JULY</b> Day <b>17</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>4:26 P.M.</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>   |  |   |                                | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>  |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-64-4474</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 11 1953</b>                                     |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |
|   | Usual Residence of Decedent   |  |   |                                |  |  |   |   |
| To Be Completed by Funeral Director           | 10a. State<br><b>MARYLAND</b>   | 10b. County<br><b>ANNE ARUNDEL</b>   | 10c. City, Town or Location<br><b>MILLERSVILLE</b>  |                                |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |
|   | 10e. Street and Number<br><b>8488 VETERANS HWY.</b>   |  |   |                                | 10f. Zip Code<br><b>21108</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | College (1-4 or 5+) <b>WAITRESS</b>   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>RESTAURANT</b>   |  | 16b. Kind of Business/Industry  |   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>CHARLES SMITH</b>   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARIE BRINKMEYER</b>   |  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARIE SMITH/ MOTHER</b>  |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>713 DEAWARE AVE. GLEN BURNIE, MARYLAND 21060</b>   |  |   |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN CEMETERY</b>  |                                | Date<br><b>7/20/1996</b>   |  | 20c. Location - City or Town, State<br><b>GLEN BURNIE, MARYLAND</b>                         |   |
|   | 21. Signature of Funeral Service Licensee<br><br><b>Hilary L. Stallings Jr.</b>   |  | 22. Name and Address of Facility<br><b>STALLINGS FUNERAL HOME P.A.<br/>3111 MOUNTAIN ROAD PASADENA, MARYLAND 21122</b>  |                                |  |  |   |   |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PYELONEPHRITIS</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |   |                                |  |  |   | Approximate Interval Between Onset and Death  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |                                |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |                                |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |                                |  |  |   |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                |  |  |   |   |
|   | 29b. Signature and title of certifier<br><br><b>David R. Fowler</b>   |  | 29c. License number<br><b>O.C.M.E.</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>JULY 18, 1996</b>  |  |   |   |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |                                |  |  |   |   |
|   | 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |  |   |                                |  |  |   |   |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21826

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |  |   |
|--|---|---|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas Savage JR.</b>                        |   |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>18</b> Year <b>1996</b> |  | 3. Time of Death<br><b>5:04 p.m.</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>             |  | 4c. County of Death<br><b>BALTIMORE</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-05-6395</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                       | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 11, 1910</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |   |
| 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>253 S. HILTON STREET</b>  |   |   |  | 10f. Zip Code<br><b>21229</b>   |  | 10g. Citizen of What Country?<br><b>USA.</b>                                     |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>          |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12+4 GRADE</b> Collage (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LONG SHORE MAN</b>  |  | 16b. Kind of Business/Industry<br><b>STEAMSHIP TRADE ASSN.</b>                   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>THOMAS SAVAGE SR.</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELIZA BUCK</b>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>THOMAS G. SAVAGE</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>253 S. HILTON ST., BALTIMORE, MD. 21229</b>   |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUS CEMETERY</b>   |  | 20c. Location (City or Town, State)<br><b>7-25-96 ARBUTUS, MARYLAND</b>   |  | 20d. Date  |  |   |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Myocardial infarction, subendocardial</b><br>Due to (or as a consequence of):<br><br>b. <b>Coronary atherosclerosis</b><br>Due to (or as a consequence of):<br><br>c. <b>Myocardial left ventricular hypertrophy</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>11 days</b><br><br><b>years</b><br><br><b>years</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Nephrosclerosis</b><br><br><b>Myocardial infarct, old, healed</b>   |   |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how Injury occurred   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D09990</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 19, 1996</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael E. Pelczar, M.D. - St. Agnes HealthCare - 900 Caton Ave., Baltimore, Md.</b>  |   |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |   |   |  | 32. Registrar's Signature<br>   |  |  |  |   |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21827

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |  |   |
|---|---|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>BETTY HELENA VOGTMAN                      |   |  |  | 2. Date of Death<br>Month Day Year<br>JULY 21 1996 |  | 3. Time of Death<br>5:02 PM  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>7981 TICK NECK ROAD |   |  |  | 4b. City, Town, or Location of Death<br>PASADENA   |  | 4c. County of Death<br>ANNE ARUNDEL  |   |
| Funeral<br>Director   | 5. Social Security Number<br>235-44-5334  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>65 Yrs.  | If Under 1 Year<br>Months Days                     | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>SEPT 22 1930  | 9. Birthplace (State or Foreign Country)<br>WEST VIRGINIA   |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |   |
| 10a. State<br>MARYLAND  |   | 10b. County<br>ANNE ARUNDEL   |  | 10c. City, Town or Location<br>PASADENA  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br>7981 TICK NECK ROAD   |   |   |  | 10f. Zip Code<br>21122   |  | 10g. Citizen of What Country?<br>USA   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER   |  | 16b. Kind of Business/Industry<br>HOUSEHOLD  |  |   |
| 17. Father's Name (First, Middle, Last)<br>MICHAEL PRESTON  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ELIZABETH ANN DUDASH  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>PATRICIA A. CARSON - DAUGHTER   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7981 TICK NECK ROAD, PASADENA, MD 21122   |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>CEDAR HILL CEMETERY   |  | Date<br>7-25-96  |  | 20c. Location - City or Town, State<br>GLEN BURNIE, MD   |  |   |
| 21. Signature of Funeral Service Licensee<br>HILARY L. STALLINGS  |   |   |  | 22. Name and Address of Facility<br>STALLINGS FUNERAL HOME, P.A.<br>3111 MOUNTAIN ROAD, PASADENA, MD 21122   |  |  |  |   |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Cervical cancer</u><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>Approx. 5 mos.  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>Daniel J. Konick, M.D.   |  | 29c. License number MD<br>D32353   |  | 29d. Date signed (Month, Day, Year)<br>7-23-96   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Daniel J. Konick, M.D., 180 Adm. Cochrane Dr., Annapolis, MD 21401  |   |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1996  |   | 32. Registrar's Signature<br>John Davidson-Randall  |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21828

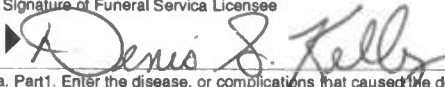
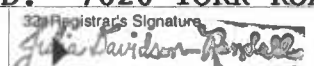
## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>EUGENE WOLF</b>  |  |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>23</b> Year <b>1996</b>  |  |   |  | 3. Time of Death<br><b>4:08 PM</b>   |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SAINT JOSEPH MEDICAL CENTER</b>  |  |   |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |  |  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| 5. Social Security Number<br><b>213-26-9823</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>7-6-29</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |  |   |  |   |  |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Bel Air</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>491-1 Moores Mill Rd.</b>  |  |   |  |   |  | 10f. Zip Code<br><b>21014</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Business Owner</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>Wolf's Chocolates</b>                                     |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Wolf</b>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Breighner</b>   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anne Wolf / wife</b>   |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>491-1 Moores Mill Rd. Bel Air, MD 21014</b> |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Cemetery</b>  |  | Date<br><b>7-27-96</b>  |  | 20c. Location - City or Town, State<br><b>Glen Burnie, MD</b>                                  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  |   |  | 22. Name and Address of Facility<br><b>Cvach/Rosedale Funeral Home<br/>1211 Chesaco Ave. Baltimore, MD 21237</b>                                |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   |  |   |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
| a. <b>CARDIOGENIC SHOCK</b><br>Due to (or as a consequence of):   |  |   |  |   |  |   |  |  |  | <b>12 HOURS</b>  |  |
| b. <b>ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):   |  |   |  |   |  |   |  |  |  | <b>24 HOURS</b>  |  |
| c. _____<br>Due to (or as a consequence of):  |  |   |  |   |  |   |  |  |  |  |  |
| d. _____<br>Due to (or as a consequence of):  |  |   |  |   |  |   |  |  |  |  |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how Injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  |   |  | 29c. License number<br><b>D 30042</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/23/96</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARK G. MIDEI, M.D. 7620 YORK ROAD TOWSON MARYLAND 21204</b>   |  |   |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>   |  |   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21829

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ora Nanaliene Watson

2. Date of Death

Month  
07Day  
21Year  
96

3. Time of Death

6:30 p.m.

4a. Facility Name (If not institution, give street and number)

2910 Dunbrin Court

Apt C.

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-34-8131

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Apr. 5, 1935

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2910 Dunbrin Court, Apt. C

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembler

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Holly Ernest Whitt

18. Mother's Name (First, Middle, Maiden Summa)

Hallie Oneal Rouse

19a. Informant's Name/Relationship (Type, Print)

Patricia K. Stein (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1926 Searles Road Baltimore, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

7/25/96

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Avenue Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Minutes

b.

Arteriosclerosis

Due to (or as a consequence of):

Unknown

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

d.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 36430

29d. Date signed (Month, Day, Year)

7/22/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara H. Richardson, MD

2112 Dundalk

Baltimore 21222

31. Date filed (Month, Day, Year)

JUL 24 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed without delay after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed without delay after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





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State of Maryland / Department of Health and Mental Hygiene

96 21830

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |  |   |  |
|--|---|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Frank William Wiggins</b>  |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>21</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>12:45 pm</b>  |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Bayview Medical Center</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>111-23-5897</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 25, 1935</b>  | 9. Birthplace (State or Foreign Country)<br><b>Massachusetts</b>                               |   |  |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Edgemere</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>23 Kropf Lane</b>  |   |   |  | 10f. Zip Code<br><b>21219</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9 Years</b> College (1-4 or 5+) <b></b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>   |  | 16b. Kind of Business/Industry<br><b>Grocery</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Frank Wiggins</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie R. Sestito</b>  |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria A. Wiggins (Wife)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23 Kropf Lane Edgemere, Maryland 21219</b>   |  |  |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Serv. Corp.</b>  |  | Date<br><b>7/24/96</b>   |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Avenue Dundalk, Maryland 21222</b>  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiorgan system failure</b><br>Due to (or as a consequence of):<br><b>60 % TBSA 2 and 3 burns</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><br><b>c. Due to (or as a consequence of):</b><br><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>6-16-96 to 7-21-96</b> |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)<br><b>6-16-96</b>  |   | 28b. Time of Injury<br><b>10:00</b> M            |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>housefire</b>  |   |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>home</b>   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>23 Kropf Lane, Sparrows Point, MD</b>                           |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>N5444</b>              |  | 29d. Date signed (Month, Day, Year)<br><b>July 22, 1996</b>  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>2 Nychwood Ct #202</b>  |   | Johns Hopkins Bayview Medical Center<br>4940 Eastern Avenue, Baltimore, MD  |   |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |   | 32. Registrar's Signature<br>   |   |  |  |  |  |  |   |  |

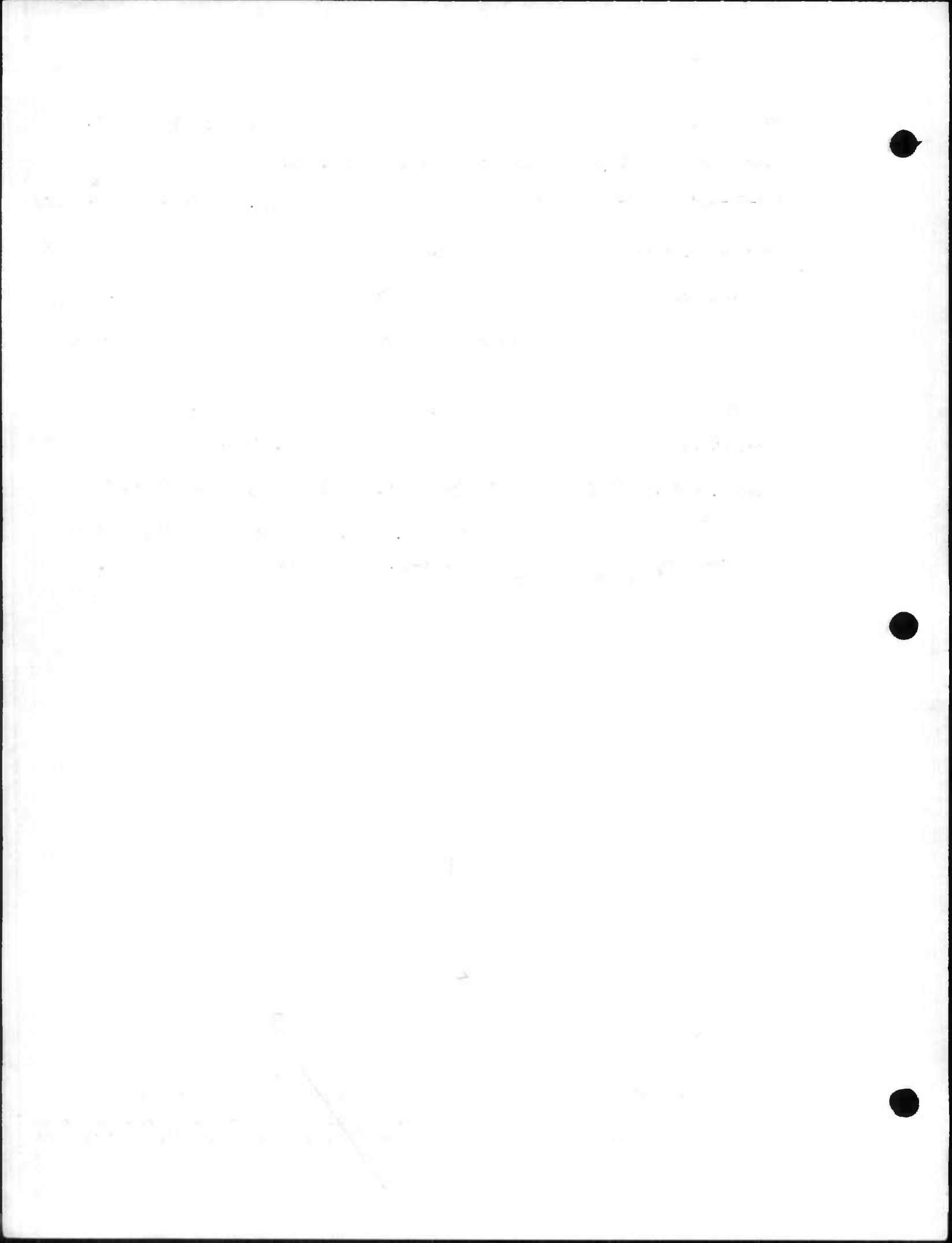
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 21831

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Andrew J. Wehner, Jr.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 19, 1996</b>  |  | 3. TIME OF DEATH<br><b>9:00 a. M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-18-5985</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 28, 1924</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Dundalk</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 9b. FACILITY NAME (If not institution, give street and number)<br><b>1925 Haselmere Road</b>  |  |  |  | 10. RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                 |  |
| 10e. STREET AND NUMBER<br><b>1925 Haselmere Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21222</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10 years</b><br>College (1-4 or 5+) <b>Crane Repairman</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Steel</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Andrew J. Wehner, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Catherine E. Brazier</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Katherine Wehner (Wife)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1925 Haselmere Road Baltimore, Maryland 21222</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Grds. 7/22/96 Timonium, Maryland</b>   |  | 20c. LOCATION — City or Town, State   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Avenue Dundalk, Maryland 21222</b> |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Johany K. Gidd</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic bronchogenic lung cancer</b><br><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HTBP</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Norad Attanasio</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-28097</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/29/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>1012 OLD NORTH Point Road Balt. Md. 21015</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 24 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
item #1,23b,24a,27,28a-f, filing 737, 7/24/96 cyw, per ME

Certificate of Death

96 21832

Reg. No.

|  |  |  |   |  |  |   |   |   |  |   |  |
|--|--|--|---|--|--|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Sanford R. Walters</u>  |  |   |  | 2. Date of Death<br>Month <u>July</u> Day <u>3</u> Year <u>1996</u>  |   |   |   | 3. Time of Death<br><u>5:45 p</u>  |   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><u>Mercy Hospital</u>  |  |   |  | 4b. City, Town, or Location of Death<br><u>Baltimore City</u>  |   |   |   | 4c. County of Death<br><u>Baltimore</u>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>217-42-7899</u>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>51</u> Yrs.   | If Under 1 Year<br>Months <u>  </u> Days <u>  </u>   | If Under 24 Hrs.<br>Hours <u>  </u> Min. <u>  </u>  | 8. Date of Birth<br>(Month, Day, Year)<br><u>Dec 24, 1944</u>   |   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>  |   |  |
|  | Usual Residence of Decedent  |  |   |  |  |   |   |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><u>MD</u>  |  | 10b. County<br><u>Howard</u>  |  | 10c. City, Town or Location<br><u>Savage</u>   |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|  | 10e. Street and Number<br><u>8436 Woodward Street</u>  |  |   |  | 10f. Zip Code<br><u>20763</u>  |   | 10g. Citizen of What Country?<br><u>U.S.A</u>                   |   |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>white</u>                               |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u>  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Machinist</u>  |  |   | 16b. Kind of Business/Industry<br><u>Prototype Machine Work</u> |   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><u>Keithen Walters</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Beulah Wines</u>   |   |   |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Frances Wines / Sister</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>8436 Woodward Street Savage, Md. 20763</u>   |   |   |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Savage Cemetery</u>  |  | Date<br><u>7/6/96</u>  |   | 20c. Location - City or Town, State<br><u>Savage, Maryland</u>  |   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>  |  |   |  | 22. Name and Address of Facility<br><u>Donaldson Funeral Home P.A.</u><br><u>313 Talbott Avenue Laurel, Md. 20707</u>  |   |   |   |  |   |  |
|  | 23a. Pert. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. (2) SUBDURAL HEMATOMA AND (2) TEMPOROPARIETAL CONTUSION</u><br>Due to (or as a consequence of):<br><u>b. Motor vehicle accident</u><br>Due to (or as a consequence of):<br><u>c. </u><br>Due to (or as a consequence of):<br><u>d. </u><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><u>Upper GI Bleed, Meningitis, Posterior Cerebral Artery Infarct, Hydrocephalus</u> |  |   |  |  |   |   |   | Approximate Interval Between Onset and Death<br><u>~ 84 days</u>   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Upper GI Bleed, Meningitis, Posterior Cerebral Artery Infarct, Hydrocephalus</u>  |  |   |  |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>HOSPICE</u> |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)<br><u>4-9-96</u> |   | 28b. Time of Injury<br><u>2215 p M</u>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred<br><u>Pedestrian struck by truck</u>                                |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   | 29b. Signature and title of certifier<br><u>[Signature]</u>  |  |   |   | 29c. License number<br><u>D40480</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>July 3, 1996</u>  |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><u>FERNANDO J. FERRO, MD</u><br><u>BALTO., MD 21206</u>  |  |  |   | 31. Date filed (Month, Day, Year)<br><u>JUL 24 1996</u>  |  |   |   | 32. Registrar's Signature<br><u>[Signature]</u>   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21833

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>CORANZO   |  | WELLS   |  | 2. Date of Death<br>Month Day Year<br>JULY 19, 1996  |  | 3. Time of Death<br>12:58 PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL  |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE CITY   |  | 4c. County of Death<br>BALTIMORE, CITY  |  |
| Funeral<br>Director  | 5. Social Security Number<br>417-26-1693  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>73 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>7/26/22  |  |
|  | 9. Birthplace (State or Foreign Country)<br>ALABAMA   |  | 10a. State<br>MARYLAND  |  | 10b. County<br>BALTIMORE, CITY   |  | 10c. City, Town or Location<br>BALTIMORE  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br>4576 DERBY MANOR DRIVE  |  | 10f. Zip Code<br>21215   |  | 10g. Citizen of What Country?<br>U.S.A.   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW2   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK  |  |
| To Be Completed by Physician/Medical Examiner                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>STEEL WORKER  |  | 16b. Kind of Business/Industry<br>BETHLEHEM STEEL  |  | 17. Father's Name (First, Middle, Last)<br>HORMONY WELLS  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br>POCAHONTAS WELLS   |  | 19a. Informant's Name/Relationship (Type, Print)<br>VERMA WELLS (WIFE)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4576 DERBY MANOR DRIVE BALTIMORE, MARYLAND 21217  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |
| Physician<br>/Medical<br>Examiner  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GARRISON FOREST   |  | 20c. Date<br>7/25/96  |  | 20d. Location - City or Town, State<br>OWINGSMILL, MARYLAND  |  | 21. Signature of Funeral Service Licensee<br><i>Estep</i>   |  |
|  | 22. Name and Address of Facility<br>ESTEP BROTHERS FUNERAL HOME PA.<br>1300 EUTAW PLACE BALTIMORE, MARYLAND 21217   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Intra cranial Hemorrhage<br>Due to (or as a consequence of):<br>b. Coagulopathy<br>Due to (or as a consequence of):<br>c. Thrombocytopenia<br>Due to (or as a consequence of):<br>d. Hypertension |  | Approximate Interval Between Onset and Death<br>15 hours<br>15 hours<br>16 days<br>74 months   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Acute Renal Failure; Infection;<br>Anemia; Internal Hemorrhage; Ischemic Bowel; Thoraco-Abdominal Aortic Aneurysm   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br>N/A  |  | 28b. Time of Injury<br>M  |  |
| To Be Completed by Physician/Medical Examiner                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Dean Chou, MD</i> SURGERY HOUSE OFFICER   |  | 29c. License number<br>N7947   |  | 29d. Date signed (Month, Day, Year)<br>07/19/96   |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>DEAN CHOU, Johns Hopkins Hospital, Tower 100, Baltimore, MD 21287   |  | 31. Date filed (Month, Day, Year)<br>JUL 24 1996  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |  | 33. Registrar's Title<br>Registrar  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21834

## Certificate of Death

Reg. No.

|  |   |  |  |                                |  |
|--|---|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Warren Wilkinson</b>  |  | 2. Date of Death<br>Month <b>July</b> Day <b>22</b> Year <b>1996</b>   |                                | 3. Time of Death<br><b>22:55P</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>   |                                | 4c. County of Death<br><b>MONTGOMERY</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-16-6328</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>72</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 11, 1924</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |                                |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |  |                                |  |
|  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore Co</b>   | 10c. City, Town or Location<br><b>Lutherville</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>20 Castlehill Court</b>  |  | 10f. Zip Code<br><b>21093</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>                           |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b> |                                |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chemical Engineer</b>   |  | 16b. Kind of Business/Industry<br><b>Lord Baltimore Press</b>  |                                |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Harmon Wilkinson</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fannie Rullman</b>   |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jessie Wilkinson (Daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20 Castlehill Court, Lutherville, Md 21093</b>                                       |                                |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Cemetery</b>  |                                | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>A. Alan Seitz, Jr.</b>  |  | 22. Name and Address of Facility<br><b>A. Alan Seitz, Jr. Funeral Home<br/>3818 Roland Avenue, Baltimore, Md. 21211</b>  |                                |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CEREBROVASCULAR ACCIDENT</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |  |  |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |  |                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b>   |   |  |  |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  |   |  |  |                                |  |
| 28a. Date of Injury (Month, Day, Year)   |   |  |  |                                |  |
| 28b. Time of Injury<br><b>M</b>  |   |  |  |                                |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |                                |  |
| 28d. Describe how Injury occurred  |   |  |  |                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |                                |  |
| 29b. Signature and title of certifier<br><b>James Michael Anchors, MD</b>  |   |  |  |                                |  |
| 29c. License number<br><b>D29730</b>   |   |  |  |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>JULY 23, 1996</b>  |   |  |  |                                |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JAMES MICHAEL ANCHORS, MD, 16220 FREDERICK RD, GAITHERSBURG MD</b>  |   |  |  |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |   |  |  |                                |  |
| 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |   |  |  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



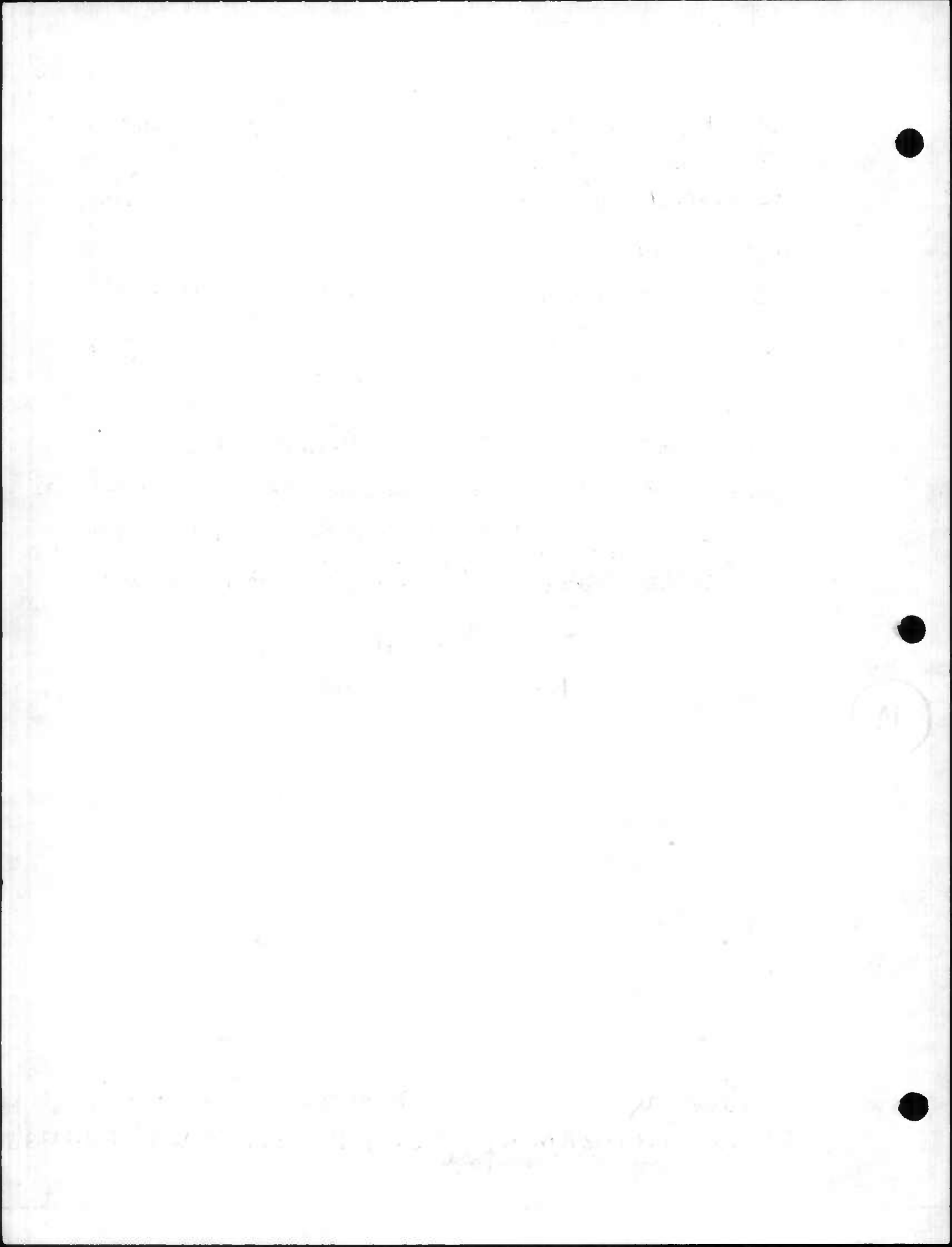
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 21835

Reg. No.

|   |   |  |   |   |  |  |   |  |  |  |
|---|---|--|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Dorothy G. Young  |  |   |   | 2. Date of Death<br>Month 7 Day 21 Year 96   |  | 3. Time of Death<br>2:30 p.m.   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>3834 Brownhill Rd   |  |   |   | 4b. City, Town, or Location of Death<br>Randallstown   |  | 4c. County of Death<br>Baltimore  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>214-22-2031  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>81 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth (Month, Day, Year)<br>July 13, 1915  |  | 9. Birthplace (State or Foreign Country)<br>Md |  |
|   | Usual Residence of Decedent   |  |   |   |  |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>md  |  | 10b. County<br>N/A  |   | 10c. City, Town or Location<br>Baltimore   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>933 South Baylis St   |  |   |   | 10f. Zip Code<br>21224   |  | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                            |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th College (1-4 or 5+) N/A   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>House parent   |   |  | 16b. Kind of Business/Industry<br>state of md. |   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Fred Owens   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie Brewer  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Dolores Rice - Daughter   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3834 Brownhill Rd Randallstown, Md 21133  |  |   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>King Memorial Plc   |   | Date<br>7/24/96  |  | 20c. Location - City or Town, State<br>Randallstown, md                                     |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Portia Elton   |  |   |   | 22. Name and Address of Facility<br>March F.H. West<br>4300 Wabash Avenue Baltimore, Md 21215  |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Renal failure<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred              |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>[Signature]  |   |  |  | 29c. License number<br>D15634   |  | 29d. Date signed (Month, Day, Year)<br>7-22-96 |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>S. KULATUNGAM MD 8020 Belair Rd Balto. Md. 21236  |  |   |   |  |  |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>JUL 24 1996  |  |   |   | 32. Registrar's Signature<br>[Signature]   |  |   |  |  |  |



96 21836

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOAN R. ZUKAS</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>JULY</b> DAY <b>20</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>11:15 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-36-4306</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>57</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 10, 1939</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>8221 Park Haven Rd.</b>   |  |   |  | 10f. ZIP CODE<br><b>21222</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b><br>College (1-4 or 5+) <b>College</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clarence W. Ross</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Grace E. Hess</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John Zukas Husband</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8221 Park Haven Rd. Dundalk, Md. 21222</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cem. 7-23</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Anthony C. Connelly</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Dundalk<br/>7110 Sollers Point Rd. 21222</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC BREAST CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>5 yrs.</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kendall Faulkner</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D25643</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/22/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 24 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Jana Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 25 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21837

Reg. No.

|  |   |   |   |   |   |  |  |  |
|--|---|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Beulah Agnes Zechman                        |   |   |   | 2. Date of Death<br>Month Day Year<br>July 18, 1996 |  | 3. Time of Death<br>8 AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>3553 Sweet Air Street |   |   |   | 4b. City, Town, or Location of Death<br>Baltimore   |  | 4c. County of Death<br>Baltimore City  |  |
| Funeral<br>Director  | 5. Social Security Number<br>219-16-4262  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>73 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Birth (Month, Day, Year)<br>April 26, 1923  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent   |   |   |   |   |  |  |  |
| 10a. State<br>Maryland   |   | 10b. County<br>Baltimore City   |   | 10c. City, Town or Location<br>Baltimore  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br>3553 Sweet Air Street  |   |   |   | 10f. Zip Code<br>21211  |   | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |   |  | 16b. Kind of Business/Industry<br>Own Home   |  |
| 17. Father's Name (First, Middle, Last)<br>William Wagner  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mabel Gordon   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Karen Zechman Daughter   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1332 Berry Street, Baltimore, Maryland 21211   |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Maryland Veterans Cemetery  |   | 20c. Location - City or Town, State<br>Garrison Forest, MD   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Lynn Burgee-Henss</i>  |   |   |   | 22. Name and Address of Facility<br>Burgess-Henss Funeral Home 21211<br>3631 Falls Road, Baltimore, Maryland  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>Congestive Heart Failure</i><br>Due to (or as a consequence of):<br>b. <i>Hypertensive Heart Disease</i><br>Due to (or as a consequence of):<br>c. <i>Renal Failure</i><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |   |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypothyroidism</i><br><i>Chronic Schizophrenia</i>  |   |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28d. Describe how injury occurred  |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |   | 29b. Signature and title of certifier<br><i>Diadema Simon-Beltran, M.D.</i>   |   | 29c. License number<br>D10732  |  | 29d. Date signed (Month, Day, Year)<br>7-18-96                                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>DIADERMA SIMON-BELTRAN, M.D. 701 W. 36th ST. BALTO, MD 21211</i>  |   |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1996   |   |   |   | 32. Registrar's Signature<br><i>Julia [Signature]</i>   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





96 21838

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Victor D. Abbott</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 10 1996</b>   |  | 3. TIME OF DEATH<br><b>4:50 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-09-5854</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 30, 1914</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Crisfield</b>   |  | 9c. COUNTY OF DEATH<br><b>Somerset</b>  |  |
| 9b. FACILITY NAME (If not institution, give street and number)<br><b>Alice Byrd Tawes Nursing Home</b>   |  |  |  | RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Somerset</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Crisfield</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>454 Charlotte Ave.</b>  |  |  |  | 10f. ZIP CODE<br><b>21817</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 1</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Ship Carpenter</b>          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Marine</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Daniel Abbott</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ida Hibble</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Victoria Huffman (daughter)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4605 Jacksonville Road - Crisfield, MD 21817</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sunnyridge Memorial Park 7/12/96</b>                   |  | 20c. LOCATION — City or Town, State<br><b>Crisfield, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert H. Bradshaw</i><br><b>Robert H. Bradshaw</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bradshaw &amp; Sons Funeral Home<br/>306 W. Main St. - Crisfield, MD 21817</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | <b>Arteriosclerotic Cardiovascular Disease</b>   |  |   |  | Approximate Interval Between Onset and Death<br><b>5 yrs</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | <b>Generalized Atherosclerosis</b>   |  |   |  | <b>10 yrs</b>   |  |
|  |  |  |  |   |  |   |  |
|  |  |  |  |   |  |   |  |
|  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CVA &amp; Rt. Hemiparesis. Organic Brain Syndrome<br/>COPD with Bronchitis<br/>Hypertension. Organic Dementia</b>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                          |  | OTHER:<br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Gregorio M. Belloso M.D.</i><br><b>Gregorio M. Belloso M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 29505</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7-10-96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DR., SALISBURY, MD 21801</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 12 1996</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Nov. 1, 1911

Dear Sir,

Very

Yours

Respectfully

Yours

Wm. H. H. H.

1911

1911

1911

I have the honor to acknowledge the receipt of your letter of the 1st inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,

Sir,

Yours very respectfully,

Wm. H. H. H.

Wm. H. H. H.

96 21839

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |   |  |
|--|--|--|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Henrietta Adams   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 12, 1996   |  |  |   | 3. TIME OF DEATH<br>7:45 P.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-48-5573   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>93 YRS.  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Jun 11, 1903  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                 |   |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>St. Mary's Nursing Center  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Leonardtwn   |  |  |   | 9c. COUNTY OF DEATH<br>St. Mary's   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |   |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>St. Mary's  |  | 10c. CITY, TOWN OR LOCATION<br>Valley Lee   |  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>P.O. Box 253   |  |  |  | 10f. ZIP CODE<br>20692  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th Grade  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph Boothe   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elizabeth Cecelia Hammett  |  |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>J. Gregory Adams   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 253, Valley Lee, MD 20692   |  |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. George Cath. Cemetery 7/17/96   |  | 20c. LOCATION — City or Town, State<br>Valley Lee, MD   |  |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael L. Gardiner</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650   |  |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIO RESPIRATORY FAILURE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>CORONARY ARTERY DISEASE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br>2 hours<br>more than 20 years<br>more than 5 years  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>ATRIAL FIBRILLATION.</u>  |  |  |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>DR. MOHAMMAD A. RAHMAN, MD</i>   |  |  |  | 29c. LICENSE NUMBER<br>D50044   |  | 29d. DATE SIGNED (Month, Day, Year)<br>07/16/1996                                    |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mohammad A. Rahman, M.D. Leonardtown, MD 20650  |  |  |  |   |  |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 18 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Anderson-Harrell</i>  |  |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21840

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Lottie Brice</b>   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>7</b> Year <b>1996</b>  |  |  |  | 3. Time of Death<br><b>12:25 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>The Pines</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>  |  |  |  | 4c. County of Death<br><b>Talbot</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-30-8195</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 21, 1916</b>      |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Talbot</b>  |  | 10c. City, Town or Location<br><b>Easton</b>   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>9 Port Street</b>  |  |   |  | 10f. Zip Code<br><b>21601</b>  |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                            |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b></b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Private Duty</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joe Brice</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Andrew Thurman (Friend)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 325, St. Michaels MD 21663</b>  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chapel Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Chapel (Easton) MD</b> |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Bennie Smith Funeral Home<br/>426 Dover St. Easton MD 21601</b>   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Respiratory failure</b></p> <p>b. <b>Chronic obstructive pulmonary disease</b></p> <p>c. <b></b></p> <p>d. <b></b></p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>2 weeks</b></p> <p><b>years</b></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> |  |   |  |  |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |  |   |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |   |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  |   |  |  |  |  |  |  |  |
| 28a. Date of Injury (Month, Day, Year)   |   |  |   |  |  |  |  |  |  |  |
| 28b. Time of Injury<br><b>M</b>  |   |  |   |  |  |  |  |  |  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |  |  |  |  |  |  |
| 28d. Describe how injury occurred  |   |  |   |  |  |  |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |  |  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |  |   |  |  |  |  |  |  |  |
| 29c. License number<br><b>DZ5933</b>   |   |  |   |  |  |  |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>7-8-96</b>   |   |  |   |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MD Crowley, MD 508 Edgewild Avenue, Easton, MD 21601</b>  |   |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>  |   |  |   |  |  |  |  |  |  |  |
| 32. Registrar's Signature<br>  |   |  |   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21841

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |   |  |
|--|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Roland W Bailey</u>   |  |   |  | 2. Date of Death<br>Month <u>7</u> Day <u>6</u> Year <u>96</u>  |  | 3. Time of Death<br><u>12:45 AM</u>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>334 S. Commerce Street</u>  |  |   |  | 4b. City, Town, or Location of Death<br><u>Centreville</u>  |  | 4c. County of Death<br><u>Queen Annes</u>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>215446125</u>  |  | 6. Sex<br><u>M</u> <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><u>49</u> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><u>11/7/47</u>                                       |  |
|  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>  |  | 10a. State<br><u>Maryland</u>   |  | 10b. County<br><u>Queen Annes</u>   |  | 10c. City, Town or Location<br><u>Centreville</u>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><u>334 S. Commerce Street</u>   |  | 10f. Zip Code<br><u>21617</u>   |  | 10g. Citizen of What Country?<br><u>USA</u>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u><br><u>12th</u>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Staple Manager</u>                |  | 16b. Kind of Business/Industry<br><u>Gunston School</u>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><u>Roland E. Bailey</u>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Reba Morris</u>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Janet Jones Bailey</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>334 S. Commerce Street, Centreville, Md. 21617</u>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Md. Veterans Cemetery</u>  |  | 20c. Location - City or Town, State<br><u>Beulah, Md.</u>   |  | 20d. Date<br><u>7/15/96</u>   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><u>Bennie Smith Funeral Home</u><br><u>P.O. Box 1687, Easton, Maryland 21601</u>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Noa Small cell lung cancer</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><u>M</u>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |   |  |
| State Registrar  | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><u>D35889</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>7/11/96</u>                                       |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>509 Idlewild Ave Easton MD 21601</u>  |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 11 1996</u>  |  |  |   | 32. Registrar's Signature<br><u>Julia Davidson-Randall</u> |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21842

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |  |
|--|--|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                          | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH D. Boyle</b>  |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>4</b> Year <b>96</b>  |  | 3. Time of Death<br><b>9:21PM</b>   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>EASTON</b>  |  | 4c. County of Death<br><b>TALBOT</b>  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-56-2081</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 8, 1919</b>  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>QUEEN ANNE</b>   |  | 10c. City, Town or Location<br><b>QUEEN ANNE</b>  |  |  |
| To Be Completed by Funeral Director                        | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>730 FOX MEADOW ROAD</b>  |  | 10f. Zip Code<br><b>21657</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |
| To Be Completed by Physician/Medical Examiner              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM L. DULIN</b>  |  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>GERTRUDE M. FAVINGER</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>THOMAS I. BOYLE/HUSBAND</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>730 FOX MEADOW ROAD, QUEEN ANNE, MD 21657</b>  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                     |  |  |
| Physician<br>/Medical<br>Examiner                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. JOSEPH'S CEMETERY</b>   |  | Date<br><b>7/8/96</b>   |  | 20c. Location - City or Town, State<br><b>CORDOVA, MD</b>  |  | 21. Signature of Funeral Service Licensee<br><b>M. E. Newnam III C.F.S.P.</b>   |  |  |
|  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL H. 200 S. HARRISON ST., EASTON, MD 21601</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>b. IMMEDIATE</b><br>Due to (or as a consequence of):<br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
| Division of Vital Records, P.O. Box 68760,                 | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                 |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |
|  | 28a. Date of Injury (Month, Day, Year)<br><b>7/8/96</b>  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |
| State Registrar  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Kevin O'Keefe MD</b>  |  |  |
|  | 29c. License number<br><b>D35259</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/14/96</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>KEVIN O' KEEFE 606 DUTCHMAN'S LANE, EASTON, MARYLAND 21601</b>  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>   |  |  |
| 32. Registrar's Signature<br><b>Julia Davidson-Randall</b> |  |  |   |  |  |  |   |  |  |

1. The first part of the report is a general  
description of the project and its objectives.  
2. The second part is a detailed description of the  
methodology used in the study.

3. The third part is a description of the results  
of the study, including a discussion of the  
limitations of the study.

4. The fourth part is a conclusion and  
recommendations for future research.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21843

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |  |  |
|--|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>MARY ETTA BRYANT   |  |   |  | 2. Date of Death<br>Month Day Year<br>July 2 1996   |  | 3. Time of Death<br>11:15pm  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>352 Marlboro Road  |  |   |  | 4b. City, Town, or Location of Death<br>Lothian   |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director  | 5. Social Security Number<br>498-01-1405   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>78 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Oct 9, 1917   |  |
|  | 9. Birthplace (State or Foreign Country)<br>Missouri   |  | 10a. State<br>Maryland  |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Lothian   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>352 Marlboro Road   |  | 10f. Zip Code<br>20711  |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 Collegia (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>sales Representative   |  | 16b. Kind of Business/Industry<br>perfume manufacturing   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Riley Clinton Irvin   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rose Harley Martin   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Doris Lee Kyle / daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>201 Sunnyside Road, Warrenton, MO 63383  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Star Hope Cemetery  |  | 20c. Location - City or Town, State<br>7/9/96 Elsberry, Missouri  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>William B. [Signature]  |  |   |  | 22. Name and Address of Facility<br>Rausch Funeral Home, P.A., Owings, MD 20736   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Cardiac arrest<br>Due to (or as a consequence of):<br>b. Cerebrovascular Accident<br>Due to (or as a consequence of):<br>c. COPD<br>Due to (or as a consequence of):<br>d. Colon CA |  |   |  |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Osteoporosis<br>Femur Fracture   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)                       |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |  |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>Joan B. Lehmann, MD |   | 29c. License number<br>D44261  |   | 29d. Date signed (Month, Day, Year)<br>7/3/96  |  |  |
| 30. Name and address of person who completed cause of death (Item 28) (Type, Print)<br>Joan B. Lehmann, MD<br>Pasadena, MD 21122   |  |  |   | 31. Date filed (Month, Day, Year)<br>7/3/96                                  |   |  |  |  |
| 32. Registrar's Signature<br>Julia Hamilton-Randall  |  |  |   | 33. Date of Death<br>JUL - 5 1996  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible,**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 21844

Reg. No.

|   |  |                               |  |  |  |  |  |  |   |  |
|---|--|-------------------------------|--|--|--|--|--|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>James Martin Brooks</b>                             |                               |  |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>05</b> Year <b>1996</b> |  | 3. Time of Death<br><b>1932</b>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b> |                               |  |  |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>      |  | 4c. County of Death<br><b>Calvert</b>  |   |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>229 32 0882</b>  |                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 24, 1929</b> |  | 9. Birthplace (State or Foreign Country)<br><b>VA</b> |  |
|   | Usual Residence of Decedent  |                               |  |  |  |  |  |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Calvert</b> |  | 10c. City, Town or Location<br><b>Chesapeake Beach</b> |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>2926 Donegal Drive</b>   |  |                               |  |  | 10f. Zip Code<br><b>20732</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1947-53</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |                               |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bus Supervisor</b>   |  |  | 16b. Kind of Business/Industry<br><b>Transportation</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ralph Aaron Brooks</b>  |  |                               |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Virginia Adkins</b>   |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Virginia R. Brooks/wife</b>  |  |                               |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as 10 above</b>   |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery</b>  |  |  | Date<br><b>7-10-96</b>   |  | 20c. Location - City or Town, State<br><b>Cheltenham, MD</b>                                   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                               |  |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home, Owings, MD 20736</b>   |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>Acute Arrhythmia / Acute Myocardial Infarction</b> 2-3 days</p> <p>Due to (or as a consequence of):</p> <p>b. <b>Arteriosclerotic Cardiovascular Disease</b> years</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 10%; text-align: center;"> <p>}</p> </div> </div> |  |                               |  |  |  |  |  |  |   |  |

Approximate Interval Between Onset and Death

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21845

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |                          |   |  |  |   |   |  |  |  |  |
|--|---|---|--|---|--|--------------------------|---|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Edna Estelle Bast                                 |   |  |   | 2. Date of Death<br>Month Day Year<br>July 7, 1996 |                          |   |  | 3. Time of Death<br>1731                       |   |   |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center |   |  |   | 4b. City, Town, or Location of Death<br>Annapolis  |                          |   |  | 4c. County of Death<br>Anne Arundel            |   |   |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>218 26 0576  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>99 Yrs.          |                          | 8. Date of Birth (Month, Day, Year)<br>Dec. 8, 1896 |  | 9. Birthplace (State or Foreign Country)<br>MD |   |   |  |  |  |  |
|  | Usual Residence of Decedent   |   |  |   |  |                          |   |  |  |   |   |  |  |  |  |
| 10a. State<br>MD   |   | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Shady Side   |  |                          |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |  |  |
| 10e. Street and Number<br>1220 Bast Lane   |   |   |  | 10f. Zip Code<br>20764  |  |                          |   | 10g. Citizen of What Country?<br>USA   |  |   |   |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |                          |   | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  |   |   |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>8   |   |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>housewife  |  |                          |   | 16b. Kind of Business/Industry<br>own home   |  |   |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Ulysses Turner  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Estelle Griner   |  |                          |   |  |  |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Paul R. Bast/grandson  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8925 St. Andrews Dr., Ches. Beach, MD 20732  |  |                          |   |  |  |   |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Quaker Burying Grds.  |  | Date<br>7-12-96          |   | 20c. Location - City or Town, State<br>Galesville, MD  |  |   |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br>Rausch Funeral Home, Owings, MD 20736   |  |                          |   |  |  |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |   |  |                          |   |  |  |   |   |  |  |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <i>Pneumonia</i><br/>Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <i>3 days</i><br/><br/> <i>Many years</i> </td> </tr> <tr> <td>b. <i>COPD</i><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. <br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. <br/>Due to (or as a consequence of):</td> </tr> </table> |   |   |  |   |  |                          |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>Pneumonia</i><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br><i>3 days</i><br><br><i>Many years</i> | b. <i>COPD</i><br>Due to (or as a consequence of): | c.<br>Due to (or as a consequence of): | d.<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. <i>Pneumonia</i><br>Due to (or as a consequence of):                                       | Approximate Interval Between Onset and Death<br><br><i>3 days</i><br><br><i>Many years</i>  |  |   |  |                          |   |  |  |   |   |  |  |  |  |
|  | b. <i>COPD</i><br>Due to (or as a consequence of):  |   |  |   |  |                          |   |  |  |   |   |  |  |  |  |
|  | c.<br>Due to (or as a consequence of):  |   |  |   |  |                          |   |  |  |   |   |  |  |  |  |
|  | d.<br>Due to (or as a consequence of):  |   |  |   |  |                          |   |  |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  |                          |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |   |  |  |  |  |
|  |   |   |  |   |  |                          |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |  |  |  |
|  |   |   |  |   |  |                          |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospitel: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |   |  |  |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |  |  |  |  |
|  |   |   |  | 28d. Describe how injury occurred   |  |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  | 29b. Signature and title of certifier<br><i>R.I. Hochman, MD</i>  |  |                          |   | 29c. License number<br>D05192  |  |   |   |  |  |  |  |
|  |   |   |  | 29d. Date signed (Month, Day, Year)<br>7/8/96   |  |                          |   |  |  |   |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>R.I. Hochman, MD 1833A Forest Dr. Annapolis, Md. 21401   |   |   |  |   |  |                          |   |  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 10 1996   |   |   |  | 32. Registrar's Signature<br><i>J. Davidson-Randall</i>   |  |                          |   |  |  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21846

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |  |  |   |
|--|--|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Alvin L Birch</i>                           |   |  |  | 2. Date of Death<br>Month <i>July</i> Day <i>5</i> Year <i>1996</i> |  | 3. Time of Death<br><i>8:14 pm</i>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Suburban Hospital</i> |   |  |  | 4b. City, Town, or Location of Death<br><i>Bethesda</i>             |  | 4c. County of Death<br><i>Montgomery</i>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><i>477-22-3567</i>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>96</i> Yrs.   | If Under 1 Year<br>Months Days                                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>May 28, 1900</i>                                     |   |
|  | 9. Birthplace (State or Foreign Country)<br><i>Philadelphia, PA</i>                        |   |  |  |   |  |  |   |
| Usual Residence of Decedent  |  |   |  |  |   |  |  |   |
| 10a. State<br><i>MD</i>  |  | 10b. County<br><i>Montgomery</i>  |  | 10c. City, Town or Location<br><i>Bethesda</i>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><i>8224 Hamilton Spring Court</i>  |  |   |  | 10f. Zip Code<br><i>20817</i>  |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>+4</i>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Engineer</i>   |   |  | 18b. Kind of Business/Industry<br><i>Manufacturing</i>   |   |
| 17. Father's Name (First, Middle, Last)<br><i>Unknown</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Lillian Wright</i>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Marie Birch - Wife</i>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>8224 Hamilton Spring Ct., Bethesda, MD 20817</i>   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Ft. Lincoln Cemetery</i>   |  | Date<br><i>7/9/96</i>  |   | 20c. Location - City or Town, State<br><i>Brentwood, MD</i>  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><i>Joseph Gawler's Sons, Inc.<br/>5130 Wisconsin Avenue, N.W.<br/>Washington, D.C. 20016</i>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Pneumonia</i><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><i>b. Due to (or as a consequence of):</i><br><i>c. Due to (or as a consequence of):</i><br><i>d. Due to (or as a consequence of):</i> |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><i>4 days</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                             |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  |   |  |  |   |
|  |  | 29c. License number<br><i>D41119</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>JULY 05, 1996</i>  |   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>JAYA SHARMA 50 - W EDMONSTON DR. ROCKVILLE MD 20852</i>   |  |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><i>JUL 08 1996</i>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21847

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

BRENDA RUTLEDGE BURTON

2. Date of Death

Month  
JulyDay  
3Year  
1996

3. Time of Death

9:15 A.M.

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardstown

4c. County of Death

St. Mary's

5. Social Security Number

240-86-6275

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 1950

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State  
Virginia

10b. County

10c. City, Town or Location

Chesapeake

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3200 Holly Ridge Court

10f. Zip Code

25233

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Homer Jefferson Rutledge

18. Mother's Name (First, Middle, Maiden Surname)

Helen Schakleford

19a. Informant's Name/Relationship (Type, Print)

Jefferson Rutledge, BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11421 SW 103rd Miami, Florida 33176

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rosewood Memorial Park

Date

7/6/96

20c. Location - City or Town, State

Virginia Beach, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Joseph Gawler's Sons, Inc.  
5130 Wisconsin Avenue, N.W.  
Washington, D.C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METHICILLIN RESISTANT STAPH PNEUMONIA

Due to (or as a consequence of):

b. ELECTROLYTE IMBALANCE

Due to (or as a consequence of):

c. COR PULMONARE

Due to (or as a consequence of):

d. COPD

Approximate Interval Between Onset and Death

3 weeks

11

11

2 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

a. ANTITRYPSIN DEFICIENCY

OSTEOPOROSIS

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thun, MD

29c. License number

D34539

29d. Date signed (Month, Day, Year)

7.3.96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. KHALID HUSAIN LEONARDTOWN, MD. 20650

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 08 1996

32. Registrar's Signature

John Davidson-Rodella

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the transparency and accountability of the organization. This section also outlines the various methods used to collect and analyze data, ensuring that the information is reliable and up-to-date.

2. The second part of the document focuses on the implementation of these practices. It details the steps involved in setting up a robust system for data collection and analysis. This includes identifying the key areas of focus, selecting appropriate tools and technologies, and training staff to ensure they are equipped to handle the data effectively. The goal is to create a seamless process that allows for the timely and accurate reporting of information.

3. The third part of the document addresses the challenges that may arise during the implementation process. It acknowledges that there may be resistance to change or a lack of resources, but it provides strategies to overcome these obstacles. By fostering a culture of collaboration and providing the necessary support, the organization can successfully navigate these challenges and achieve its goals.

4. The final part of the document concludes with a summary of the key findings and recommendations. It reiterates the importance of maintaining accurate records and the need for a systematic approach to data collection and analysis. The document also provides a clear path forward, outlining the next steps and the responsibilities of the various stakeholders involved.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21848

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |  |   |  |
|---|--|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Phyllis Grinel Brown                         |   |   |   | 2. Date of Death<br>Month Day Year<br>July 4, 1996 |  | 3. Time of Death<br>3:55 A.M.  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Rockville Nursing Home |   |   |   | 4b. City, Town, or Location of Death<br>Rockville  |  | 4c. County of Death<br>Montgomery  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>577-60-5899   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>92 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth (Month, Day, Year)<br>Sept. 5, 1903   |  | 9. Birthplace (State or Foreign Country)<br>Rhode Island  |  |
|   | Usual Residence of Decedent  |   |   |   |  |  |  |   |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Chevy Chase  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br>4743 Bradley Blvd.  |  |   |   | 10f. Zip Code<br>20815  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Commerce Department  |  |  | 16b. Kind of Business/Industry<br>U.S. Government  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Pardon G. Gray   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Grinel   |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Laurence C. Brown/Husband   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4743 Bradley Blvd., Chevy Chase, Md. 20815   |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery |   | Date<br>July 6, 96                                 |  | 20c. Location - City or Town, State<br>Suitland, Md.   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br>DeVol Funeral Home<br>2222 Wisconsin Ave., N.W., Wash., DC 20007  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Alzheimers Dementia</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><u>dysphagia</u>  |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
|   |  |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
|   |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |   |   | 29c. License number<br>039166   |  | 29d. Date signed (Month, Day, Year)<br>July 5, 1996  |  |   |  |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br>Alvin Madarang, M.D., 6320 Democracy Blvd., Bethesda, Maryland  |  |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 09 1996  |  |   |   | 32. Registrar's Signature<br>  |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



ITEMS: 23 PART I, 27, 28a-f, PER  
MEO FILM G-737 7/26/96 t.t

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21849

## Certificate of Death

Reg. No.

|  |   |  |  |   |  |                                |   |  |
|--|---|--|--|---|--|--------------------------------|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>TRACY L. BROWN  |  |  |   | 2. Date of Death<br>Month Day Year<br>JULY 03 1996   |                                | 3. Time of Death<br>1:23 AM   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>HOLY CROSS HOSPITAL   |  |  |   | 4b. City, Town, or Location of Death<br>SILVER SPRING  |                                | 4c. County of Death<br>MONTGOMERY   |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-94-4919  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>31 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>JUNE 25, 1965  | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |
|  | Usual Residence of Decedent   |  |  |   |  |                                |   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD.   |  | 10b. County<br>MONTGOMERY  |   | 10c. City, Town or Location<br>SILVER SPRING   |                                |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  | 10e. Street and Number<br>1710 JANUARY DR.  |  |  |   | 10f. Zip Code<br>20904   |                                | 10g. Citizen of What Country?<br>U.S.A.   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | Collage (1-4 or 5+)<br>Collage (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER   |                                | 16b. Kind of Business/Industry<br>AT HOME   |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br>ROBERT BECK  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>ELLEN EMORY   |                                |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>RANDY L. BROWN SR.  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3445 BRIAR PARK EAST #2, MEMPHIS, TENNESSEE 38116   |                                |   |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>CHAMBERS CREMATORY   |   | Date<br>7/6  |                                | 20c. Location - City or Town, State<br>RIVERDALE, MD.   |  |
|  | 21. Signature of Funeral Service Licensee<br>W.W. Chambers  |  |  |   | 22. Name and Address of Facility<br>W. W. CHAMBERS CO., RIVERDALE, MD. 20737   |                                |   |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. ACUTE COCAINE INTOXICATION<br>Due to (or as a consequence of):<br><br>f.<br>Due to (or as a consequence of):<br><br>g.<br>Due to (or as a consequence of):<br><br>h.<br>Due to (or as a consequence of): |  |  |   |  |                                |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |   |  |                                |   |  |
|  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |                                |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |                                |   |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br>FOUND 7-3-96  |   | 28b. Time of Injury<br>UNKNOWN M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred<br>UNKNOWN  |  |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) 1710 JANUARY DRIVE APT. #201 SILVER SPRING, MD  |                                |   |  |
|  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |  |                                |   |  |
| State Registrar  | 29b. Signature and title of certifier<br>Dennis J. Chute MD   |  |  |   | 29c. License number<br>O.C.M.E.  |                                | 29d. Date signed (Month, Day, Year)<br>JULY 03, 1996  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201   |  |  |   |  |                                |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 09 1996                     |   | 32. Registrar's Signature<br>John Davidson |  |   |  |                                |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

1. The first part of the report is a general  
description of the project and its objectives.  
2. The second part is a detailed description of the  
methodology used in the study.  
3. The third part is a description of the results  
obtained from the study.  
4. The fourth part is a discussion of the results  
and their implications.  
5. The fifth part is a conclusion and a summary  
of the findings of the study.

Dr. J. H. Smith  
Department of Biology  
University of California  
Berkeley, California



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21850

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>LUIS A. BAQUE  |  |   |  | 2. Date of Death<br>Month JULY 8, 1996 Year   |  | 3. Time of Death<br>10:00 PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>HOLY CROSS HOSPITAL  |  |   |  | 4b. City, Town, or Location of Death<br>SILVER SPRING   |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director   | 5. Social Security Number<br>579-64-2693   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>82 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>JAN. 23, 1914                                 |  |
|   | 9. Birthplace (State or Foreign Country)<br>ECUADOR  |  | 10a. State<br>MD.   |  | 10b. County<br>MONTGOMERY   |  | 10c. City, Town or Location<br>KENSINGTON  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>3000 McCOMAS AVE.   |  | 10f. Zip Code<br>20895  |  | 10g. Citizen of What Country?<br>ECUADOR   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: ECUADOR |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOUSE KEEPER   |  | 16b. Kind of Business/Industry<br>HOME  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>SEGUNDO BAQUE   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>SENOVIA CHOEZ  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>EFRAIN BAQUE   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13123 DAIRY MAID DR., GERMANTOWN, MD. 20874  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GATE OF HEAVEN CEMETERY   |  | 20c. Location - City or Town, State<br>7/12 SILVER SPRING, MD.  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>W.W. Chambers   |  |   |  | 22. Name and Address of Facility<br>W. W. CHAMBERS CO., RIVERDALE, MD. 20737  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ASPIRATION PNEUMONIA<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate interval between Onset and Death<br>2 wks. |  |   |  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>MALNUTRITION 20 TO ANOREXIA<br>GANGRENE, T&S.  |  |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |  |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29e. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 29b. Signature and title of certifier<br>Dr. Rosenbaum   |  |   |  | 29c. License number<br>D09874   |  | 29d. Date signed (Month, Day, Year)<br>7/9/96  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>HARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD. 20895   |  |   |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 31. Date filed (Month, Day, Year)<br>JUL 10 1996   |  | 32. Registrar's Signature<br>Julia Davidson-Rodriguez   |  |   |  |  |  |
|   | 33. Registrar's Name<br>JULIA DAVIDSON-RODRIGUEZ   |  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report is a general  
description of the project and its objectives.  
It includes a brief history of the project and  
a statement of the purpose of the study.

2. The second part of the report is a detailed  
description of the methodology used in the study.  
It includes a description of the data collection  
methods and the statistical analysis techniques used.

3. The third part of the report is a discussion  
of the results of the study. It includes a  
summary of the findings and a comparison of the  
results with the objectives of the study. It also  
includes a discussion of the limitations of the study  
and suggestions for future research.

4. The fourth part of the report is a conclusion  
and a list of references. It includes a summary  
of the main findings of the study and a list of  
the sources used in the study.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21851

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Florence Borland  |  |   |  | 2. Date of Death<br>Month Day Year<br>July 9, 1996   |  |  |  | 3. Time of Death<br>9:50 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Larkin Chase Nursing and Restorative Center   |  |   |  | 4b. City, Town, or Location of Death<br>Bowie  |  |  |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>198-09-1469  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>91 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Mar. 15, 1905                                 |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  |
|   | 10a. State<br>Maryland  |  |   |  | 10b. County<br>Prince George's   |  | 10c. City, Town or Location<br>Seabrook  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br>9607 Good Luck Road   |  |   |  | 10f. Zip Code<br>20706   |  | 10g. Citizen of What Country?<br>United States                                       |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary   |  |  |  | 16b. Kind of Business/Industry<br>F.D.I.C.   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charles Durner   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annie Schufly   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Albert S. Borland, Jr.  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9607 Good Luck Road, Seabrook, Maryland 20706   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  | Date<br>7-10-96  |  | 20c. Location - City or Town, State<br>Beltsville, Maryland                          |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>Rapp Funeral Services, P.A.<br>933 Gist Avenue, Silver Spring, Maryland 20910  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Respiratory Failure<br>Due to (or as a consequence of):<br>b. Aspiration Pneumonia<br>Due to (or as a consequence of):<br>c. Senility<br>Due to (or as a consequence of):<br>d. Congestive Heart Failure<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br>1 hour   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>she was DNR   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D-34525   |  | 29d. Date signed (Month, Day, Year)<br>July 9, 1996                                  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>S. J. Rao, M.D., 4000 Mitchellville Road #220, Bowie, Maryland 20716  |  |   |  |  |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>JUL 10 1996  |  | 32. Registrar's Signature<br>   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21852

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>DOROTHY MAXINE BRUST   |  |   |  | 2. Date of Death<br>Month Day Year<br>JULY 1, 1996  |  | 3. Time of Death<br>8:10 pm  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>202 Perrywinkle Lane   |  |   |  | 4b. City, Town, or Location of Death<br>GAITHERSBURG  |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>344-16-0811   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>70 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>7/16/1925                                     |  |
|   | 9. Birthplace (State or Foreign Country)<br>Indiana  |  | 10a. State<br>Florida   |  | 10b. County<br>Lee  |  | 10c. City, Town or Location<br>N. Ft. Myers  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>398 Horizon Drive   |  | 10f. Zip Code<br>33903  |  | 10g. Citizen of What Country?<br>United States                                       |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Bookkeeper                                |  | 16b. Kind of Business/Industry<br>Education   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Jay William Myrick  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Viola Smith   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Patricia Ubik, Daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>202 Perrywinkle Lane, Gaithersburg, MD 20878   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory  |  | 20c. Location - City or Town, State<br>Alexandria, Virginia   |  | 20d. Date<br>7/2/96  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br>DeVol Funeral Home<br>10 East Deer Park Dr., Gaithersburg, MD 20877   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. METASTATIC RECTAL CANCER<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br>6 MONTHS  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
|   |  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |  |  |  |
|   | 29c. License number<br>D37236  |  |   |  | 29d. Date signed (Month, Day, Year)<br>July 3, 1996   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Carolyn B. Hendricks, M.D., 9707 Medical Center Dr., #300 Rockville, MD 20850  |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>JUL 09 1996   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,




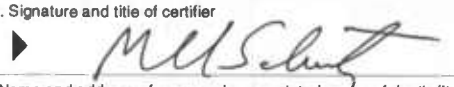
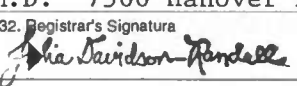
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21853

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |                          |                                |  |  |  |   |  |  |  |
|---|---|--|--|---|--|--------------------------|--------------------------------|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Edwin John Beckman</b>   |  |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>4</b> Year <b>1996</b>  |                          |                                |  | 3. Time of Death<br><b>12:00 PM</b>  |  |   |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>6706 41st Avenue</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>University Park</b>   |                          |                                |  | 4c. County of Death<br><b>Prince Georges</b>   |  |   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-07-8679</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |                          | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 12, 1912</b>           |  | 9. Birthplace (State or Foreign Country)<br><b>Indiana</b> |  |
|   | Usual Residence of Decedent   |  |  |   |  |                          |                                |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince Georges</b>   |   | 10c. City, Town or Location<br><b>University Park</b>  |                          |                                |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |  |  |
|   | 10e. Street and Number<br><b>6706 41st Avenue</b>   |  |  |   | 10f. Zip Code<br><b>20782</b>  |                          |                                |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944-1945</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                          |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b></b>   |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Audio/Visual Specialist</b>  |                          |                                |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>                                    |  |   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Frank Beckman</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Englehart</b>   |                          |                                |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rosa Lee Lindsey</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11010 Watkins Road Germantown, Maryland 20876</b>  |                          |                                |  |  |  |   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>   |                          |                                |  | Date<br><b>7/9/96</b>  |  | 20c. Location - City or Town, State<br><b>Silver Spring, Maryland</b> |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |   | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W. Sil. Spr., MD 20901</b>  |                          |                                |  |  |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |   |  |                          |                                |  |  |  |   |  | Approximate Interval Between Onset and Death               |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Ischemic Heart Disease with Prior Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Infarction</b><br>Due to (or as a consequence of):<br>c. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>d.<br>{ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |                          |                                |  |  |  |   |  | 10 Years   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation</b><br><br><b>Diabetes Mellitus</b>  |   |  |  |   |  |                          |                                |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |                          |                                |  |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                          |                                |  |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                          |                                |  |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |   |  |                          |                                |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |   |  |  | 29c. License number<br><b>D 22117</b>   |  |                          |                                | 29d. Date signed (Month, Day, Year)<br><b>July 5, 1996</b>                       |  |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael J. Schwartz, M.D. 7500 Hanover Parkway #204 Greenbelt, Maryland 20770</b>  |   |  |  |   |  |                          |                                |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>   |   |  |  | 32. Registrar's Signature<br>  |  |                          |                                |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

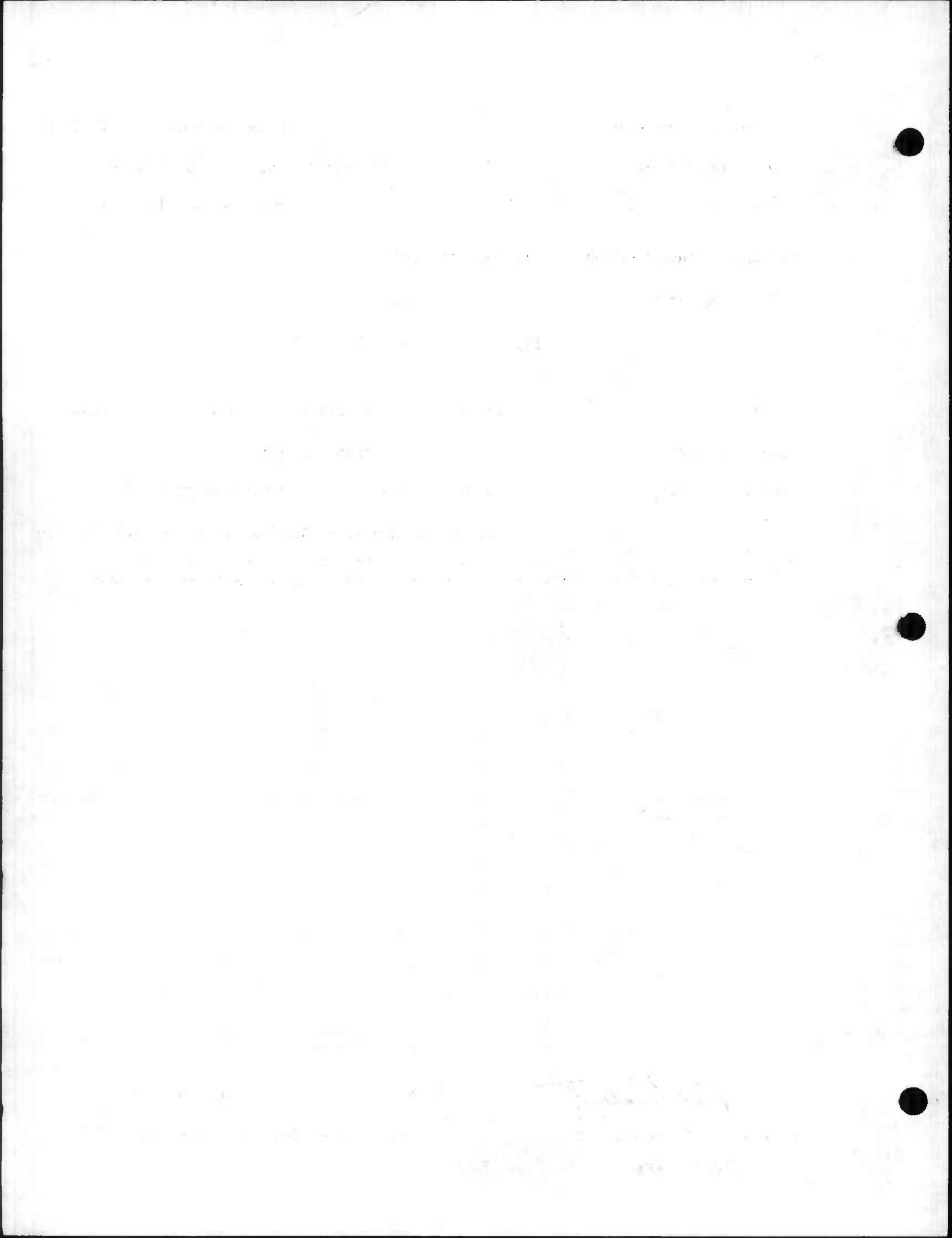
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





96 21854

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SOPHIE BAYNARD</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 8, 1996</b>   |  | 3. TIME OF DEATH<br><b>3:00 P.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>579-58-1376</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 22, 1907</b>  |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery General Hospital</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney</b>   |  | 8c. COUNTY OF DEATH<br><b>Montgomery</b>   |   |
| 9a. STATE<br><b>Maryland</b>   |  | 9b. COUNTY<br><b>Montgomery</b>  |  | 9c. CITY, TOWN OR LOCATION<br><b>Olney</b>  |  | 9d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10a. STREET AND NUMBER<br><b>17805 Buehler Road, #117</b>  |  |  |  | 10b. ZIP CODE<br><b>20832</b>   |  | 10c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (14 or 5+) <b>12 Years</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Congressional Record For Department Of Education</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jacob Baynard</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rose Hurwitz</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shirley L. Helman</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17805 Buehler Road, #117, Olney, MD 20832</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King David Memorial Garden 7/10/1996</b>   |  | 20c. LOCATION — City or Town, State<br><b>Falls Church, VA</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald S. Stettin</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL STREET, N.W.<br/>WASHINGTON, D.C. 20012-2095</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>DAYS</b><br><b>DAYS</b><br><b>DAYS</b>   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  |  |  |  |   |  |  |   |
| a. DUE TO (OR AS A CONSEQUENCE OF): <b>Pneumonia</b>   |  |  |  |   |  |  |   |
| b. DUE TO (OR AS A CONSEQUENCE OF): <b>Urinary Tract Infection</b>   |  |  |  |   |  |  |   |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hyperthyroidism</b>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO               |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert H. Knitzer, MD.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D37930</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>July 8, 1996</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert H. Knitzer, MD. Olney, Maryland 20832</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 12 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


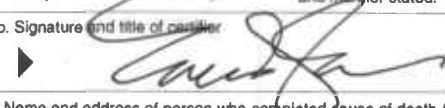
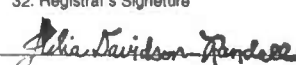
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 21855

Reg. No.

|   |   |                                       |   |   |   |   |  |  |  |
|---|---|---------------------------------------|---|---|---|---|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Carolyn Klix Boysen</b>                        |                                       |   |   |   | 2. Date of Death<br>Month <b>July</b> Day <b>10</b> Year <b>1996</b>                        |  | 3. Time of Death<br><b>5:27P.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3412 Dunnington Road</b> |                                       |   |   |   | 4b. City, Town, or Location of Death<br><b>Beltsville</b>                                   |  | 4c. County of Death<br><b>Prince George's</b>  |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>062-28-7624</b>   |                                       | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>June 3, 1937</b>         |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |
|   | Usual Residence of Decedent   |                                       |   |   |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George's</b> |   | 10c. City, Town or Location<br><b>Beltsville</b>  |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>3412 Dunnington Road</b>   |   |                                       |   |   | 10f. Zip Code<br><b>20705</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>              |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>  |   |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>                  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Hugo Klix</b>   |   |                                       |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Carpenter</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sandra Millner (Daughter)</b>  |   |                                       |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3341 Midland Court Abingdon, Maryland 21009</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |   |   | Date<br><b>7/11/1996</b>  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b> |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |                                       |   |   | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Road Beltsville, Maryland 20705</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. <b>Non Hodgkins Lymphoma, Small cell</b><br/>Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p><b>10 years</b></p> </div> </div> |   |                                       |   |   |   |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RESISTANT DISEASE TO NUMEROUS MEDICATIONS</b>  |   |                                       |   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |   |                                       |   |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |   |                                       |   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                       |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |                                       | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                       |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                                       |   |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br>  |   |                                       |   |   | 29c. License number<br><b>029294</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>July 11, 1996</b>        |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Everard Hughes, M.D. 10810 Connecticut Avenue Kensington, Maryland 20795</b>   |   |                                       |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>   |   |                                       |   |   | 32. Registrar's Signature<br>  |   |  |  |  |

To Be Completed by Funeral Director

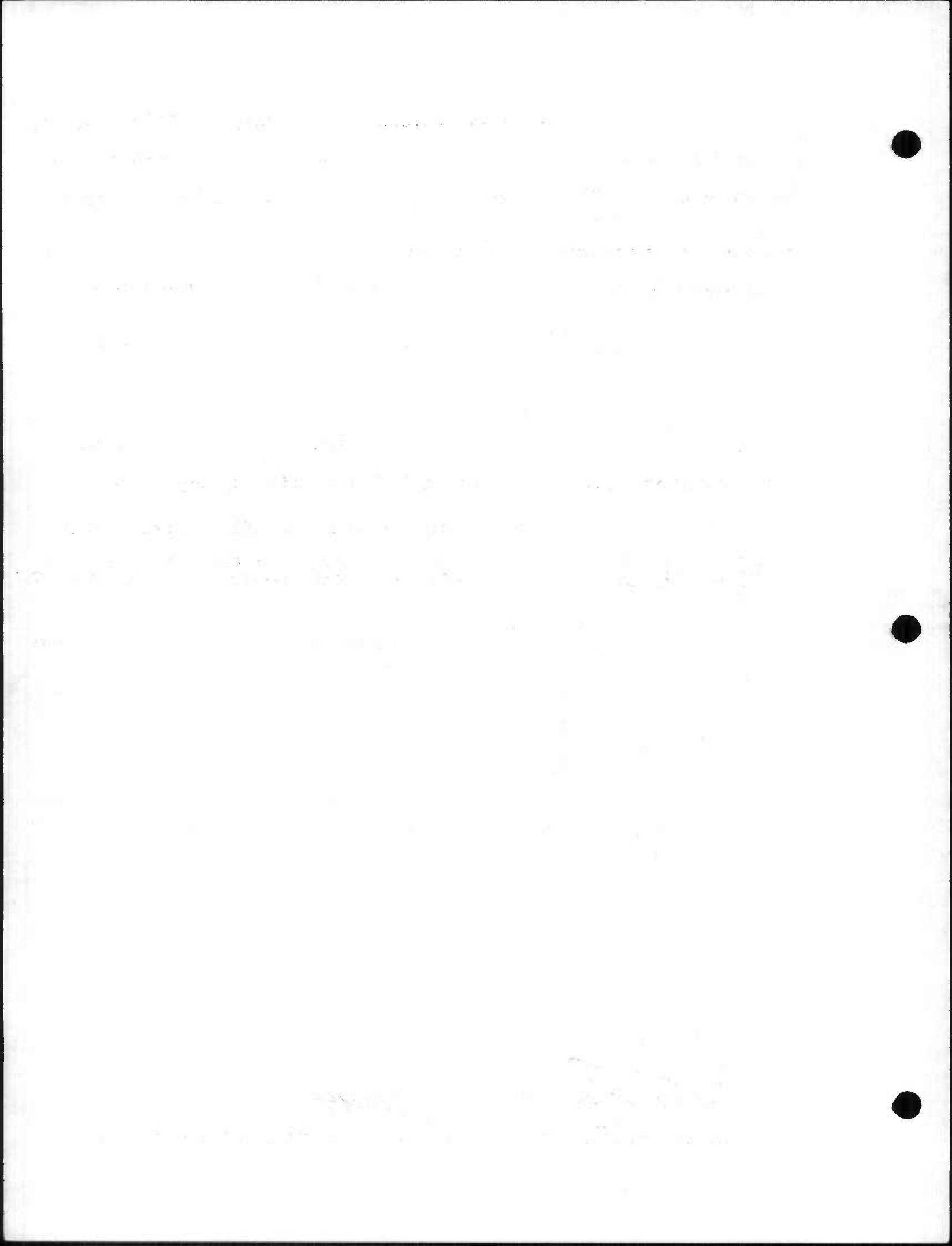
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21856

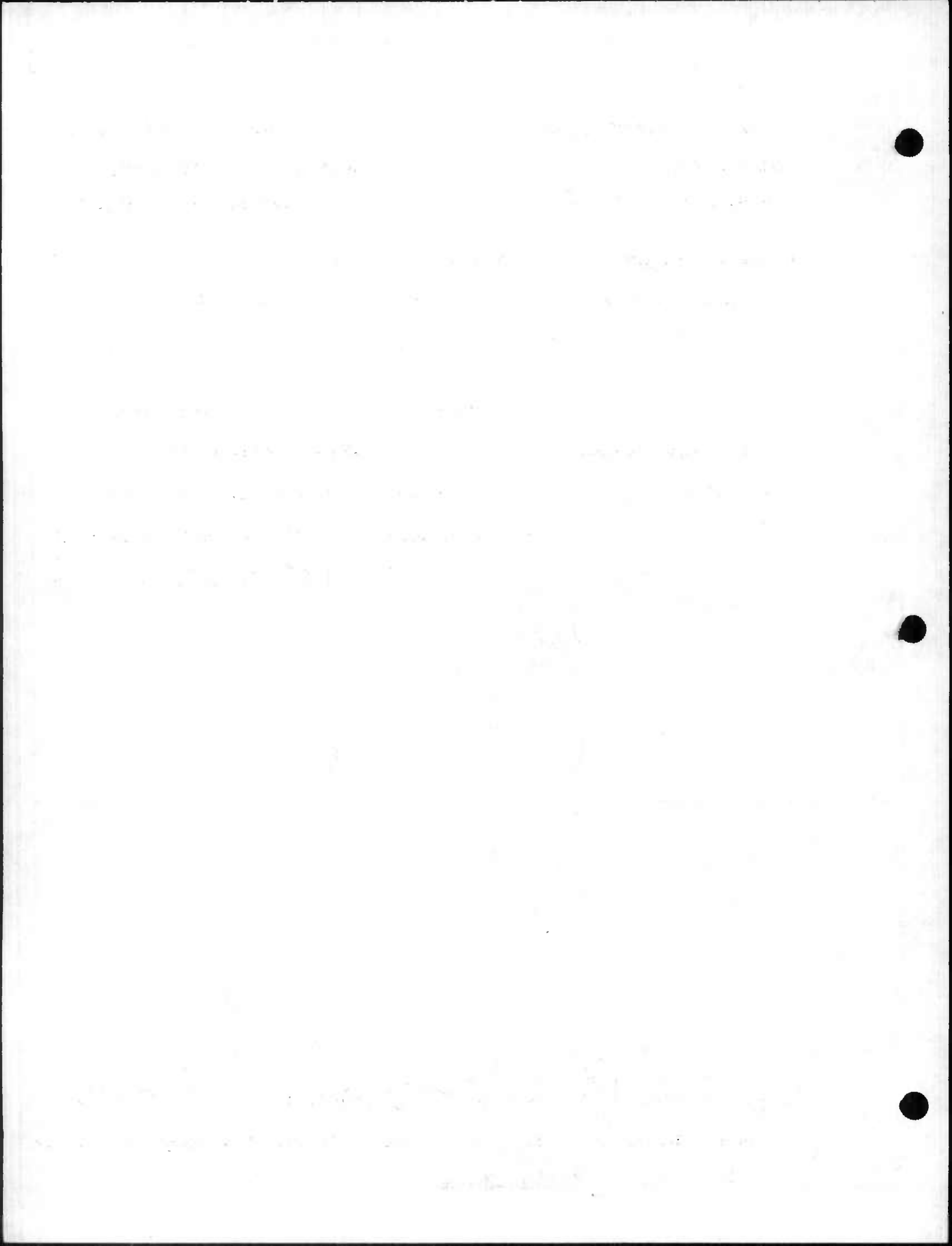
## Certificate of Death

Reg. No.

|  |   |  |   |  |   |  |   |  |
|--|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EARL BUFORD BLED SOE</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 9 1996</b>  |  | 3. Time of Death<br><b>11:57 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-05-4933</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>June 9, 1910</b>                                  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  |   |  |   |  |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |  |   |  |   |  |
|  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Wheaton</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>10703 Lester Street</b>  |  |   |  | 10f. Zip Code<br><b>20902</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Contractor</b>  |  | 16b. Kind of Business/Industry<br><b>Construction</b>                                       |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Angus Bledsoe</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Florence Barden</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Bledsoe</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10703 Lester Street, Wheaton, Maryland 20902</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Cemetery</b>  |  | Date<br><b>7/13/96</b>  |  | 20c. Location - City or Town, State<br><b>Rockville, Maryland</b>                           |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd. W. Silver Spring, MD 20901</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  |
| Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)   |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
|  | a. <b>RENAL FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>PULMONARY FAILURE</b><br>Due to (or as a consequence of):<br>c. <b>DIABETES</b><br>Due to (or as a consequence of):<br>d.  |  |   |  |   |  |   | <b>1 WEEK</b><br><br><br><br><b>1 WEEK</b><br><br><br><br><b>20 YEARS</b>  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |   |  |   |  |   |  |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |  |   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  |   |  |   |  |   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |   |  |
|  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>039004</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7-10-96</b>                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James M. Salander M.D. 11119 Rockville Pike, #204 Rockville, Maryland 20852-3143</b>  |   |  |   |  |   |  |   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>   |  |   |  | 32. Registrar's Signature<br>  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21857

## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |   |  |  |
|---|---|--|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Robert M. Bolton, Jr.</b>  |  |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>9</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>10:00AM</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>18045 Cottage Garden Drive, #103</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Germantown</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-30-4117</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>July 29, 1935</b>   |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Germantown</b>  |  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>18045 Cottage Garden Drive #103</b>  |  | 10f. Zip Code<br><b>20874</b>   |  |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1953</b><br>If Yes, Give Year or Dates: <b>1957</b> |  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+) <b>2</b>                                       |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Collector</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Banking</b>  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Robert M. Bolton, Sr.</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rozelle Harriott Jett</b>   |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia J. Bolton/ Wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18045 Cottage Garden Drive #103<br/>Germantown, Maryland 20874</b>  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium Inc.</b>  |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>  |  |  |
|   | 21. Signature of Funeral Service Licensee<br> <b>M00335</b>   |  |  |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/<br/>Rockville, Inc. 300 West Montgomery<br/>Avenue, Rockville, Maryland 20850-2805</b>  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>c. Hypertension</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>1 Day</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Exogenous Obesity</b>  |  |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 28d. Describe how Injury occurred   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br> <b>Richard N. Katon M.D.</b>   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D06258</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>July 9, 1996</b>  |  |   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Richard N. Katon, M.D. 20528 Boland Farm Road, #104, Germantown, Maryland 20876</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br> <b>Julia Davidson-Randall</b>  |  |  |  | 33. State Registrar<br><b>State Registrar</b>   |  |   |  |  |
|   | 34. DHMH 16 Rev 6/95  |  |  |  | 35. Baltimore, Maryland 21215-0020  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21858

## Certificate of Death

Reg. No.

|  |  |  |  |   |  |   |  |   |   |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HELEN CLAIRE SKELLY BABER</b>                   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>JULY 10, 1996</b> |   | 3. Time of Death<br><b>3:15 AM</b>                         |   |   |   |  |   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SOLOMONS NURSING HOME</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>SOLOMONS</b>    |   | 4c. County of Death<br><b>CALVERT</b>                      |   |   |   |  |   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-32-7362</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.           |   | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 1, 1922</b> |   | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b> |   |  |   |  |  |  |
|  | Usual Residence of Decedent  |  |  |   | 10a. State<br><b>MARYLAND</b>                              |   | 10b. County<br><b>CALVERT</b>                              |   | 10c. City, Town or Location<br><b>HUNTINGTOWN</b>               |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |  |  |
| 10e. Street and Number<br><b>3050 RICHFIELD RD.</b>  |  |  |  | 10f. Zip Code<br><b>20639</b>   |  |   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>   |   |   |  |   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                   |   |   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>2</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STATISTICIAN</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>FEDERAL GOVERNMENT</b>   |   |   |  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>WILLIAM HERMAN SKELLY</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET JANE LE FEVRE</b>  |  |   |  |   |   |   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>RALPH E. BABER / HUSBAND</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3050 RICHFIELD RD. HUNTINGTOWN, MARYLAND 20639</b>  |  |   |  |   |   |   |  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>TRINITY MEMORIAL GRDNS</b>   |  | Date<br><b>JULY 13</b>  |  | 20c. Location - City or Town, State<br><b>WALDORF, MARYLAND</b>   |   |   |  |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>BENJAMIN M. MATTHEWS</b>   |  |  |  | 22. Name and Address of Facility<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156 WALDORF, MARYLAND 20604</b>  |  |   |  |   |   |   |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Carcinoma of Breast (left)</b><br>Due to (or as a consequence of):<br><b>b. w. r. metastases</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>- 3 yrs</b>  |  |   |  |   |   |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation</b><br><b>Congestive Heart Failure</b>  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |   | 28d. Describe how injury occurred                           |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  | 29b. Signature and title of certifier<br><b>Dr. Anwar Munshi MD</b>   |  |   |  | 29c. License number<br><b>19427</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 10, 1996</b> |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANWAR MUNSHI MD 110 HOSPITAL ROAD PRINCE FREDERICK, MD. 20678</b>   |  |  |  |   |  |   |  |   |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 15 1996</b>  |  |  |  | 32. Registrar's Signature<br><b>J. Davidson-Randall</b>   |  |   |  |   |   |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report discusses the general situation of the country and the progress of the work.

2. The second part of the report discusses the results of the work and the progress of the work.

3. The third part of the report discusses the results of the work and the progress of the work.

4. The fourth part of the report discusses the results of the work and the progress of the work.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21859

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |  |  |   |   |  |
|--|--|---|--|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Mildred mae Barrett</u>                               |   |  |   | 2. Date of Death<br>Month <u>07</u> Day <u>09</u> Year <u>96</u> |  |  |   | 3. Time of Death<br><u>2000.</u>                            |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>medpointe ccc 1 price drive</u> |   |  |   | 4b. City, Town, or Location of Death<br><u>Elkton</u>            |  |  |   | 4c. County of Death<br><u>Cecil</u>                         |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>220-18-5728</u>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><u>97</u> Yrs.                 |  | 8. Date of Birth (Month, Day, Year)<br><u>Aug. 8, 1898</u> |   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u> |  |
|  | Usual Residence of Decedent  |   |  |   |  |  |  |   |   |  |
| 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Cecil</u>   |  | 10c. City, Town or Location<br><u>Colora</u>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No        |   |  |
| 10e. Street and Number<br><u>862 Fire Tower Road</u>   |  |   |  | 10f. Zip Code<br><u>21917</u>   |  |  |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                               |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) _____<br>College (1-4 or 5+) <u>Two Years</u>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Medical Staff Assistant</u>   |  |  |  | 16b. Kind of Business/Industry<br><u>Bainbridge Naval Training Ctr</u><br><u>Bainbridge, Maryland</u> |   |  |
| 17. Father's Name (First, Middle, Last)<br><u>William Davis</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Ollie Lord</u>  |  |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Paula H. Gilley (Granddaughter)</u>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>35 Oak Street, Colora, Maryland 21917</u>   |  |  |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>R.A. Ferris &amp; Company</u>  |  | Data<br><u>7/11/96</u>  |  | 20c. Location - City or Town, State<br><u>West Chester, Pennsylvania</u> |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br><u>James M. Patterson, Sr.</u>  |  |   |  | 22. Name and Address of Facility<br><u>Lee A. Patterson &amp; Son Funeral Home</u><br><u>Perryville, Maryland 21903</u>   |  |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. <u>Chronic Gastrointestinal Bleeding</u><br/>Due to (or as a consequence of):</p> <p>b. <u>Secondary Arteriovenous Malformation</u><br/>Due to (or as a consequence of):</p> <p>c. <u>Acute Gastrointestinal Bleeding</u><br/>Due to (or as a consequence of):</p> <p>d. <u>Severe Dementia -</u></p> </div> <div style="width: 15%;"> <p>5 yrs Approx</p> <p>5 yrs Approx</p> <p>1 week</p> <p>7 years Approx</p> </div> </div> |  |   |  |   |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Coronary Artery Disease &amp; Atherosclerosis</u><br><u>Hypothyroidism -</u>  |  |   |  |   |  |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           |   |  |
|  |  |   |  | 28d. Describe how Injury occurred   |  |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                          |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><u>Dr. Jayantilal K. Patel MD</u>  |  |  |  | 29c. License number<br><u>D 22307</u>   |   |  |
|  |  |   |  | 29d. Date signed (Month, Day, Year)<br><u>7/10/96</u>   |  |  |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>JAYANTILAL K PATEL MD - 123 Singerville Ave, ELKTON - MD 21921</u>  |  |   |  |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 12 1996</u>  |  |   |  | 32. Registrar's Signature<br><u>Julia Davidson-Randall</u>  |  |  |  |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Dr. BARRETT MILDRED M.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

3



96 21860

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Helen P. BENSON</i> Helen Pope Benson  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>7</i> DAY <i>9</i> YEAR <i>96</i>   |  | 3. TIME OF DEATH<br><i>1043 A M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>243-09-3245</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>83</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Jan. 24, 1913</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>North Carolina</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Union Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Elkton</i>   |  |
| 9c. COUNTY OF DEATH<br><i>Cecil</i>   |  |  |  | 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Cecil</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Chesapeake City</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>211 Bohemia Avenue</i>  |  |
| 10f. ZIP CODE<br><i>21915</i>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>white</i>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Charles E. Pope</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Elizabeth McKinnis</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Marie B. Payne/daughter</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>16 Augusta Drive, Elkton, Maryland 21921</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Bethel Cemetery</i> DATE <i>7/13/1996</i>  |  | 20c. LOCATION — City or Town, State<br><i>Chesapeake City, MD</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donned S. Hicks</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Hicks Home for Funerals, P.A.<br/>103 W. Stockton Street, Elkton, MD 21921</i>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Septic Shock</i>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| c. <i>Aspiration</i> DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. <i>Stroke (Right CVA)</i> DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>ASCVD (Coronary artery disease), SVT<br/>Fracture left hip</i>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert Denitzio M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D30291</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>7/9/96</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Robert Denitzio M.D. 111 W. High St Elkton, Md 21921</i>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>JUL 11 1996</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



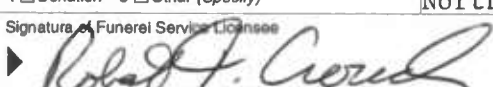
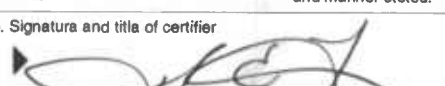
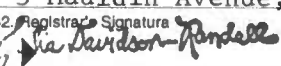
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21861

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
|---|--|---|--|--|--|--|--|--|--|---|--|--|--|----------------------------------|-------|--|-----|--|--|----------------------------------|--|--|-----------------------|----------|--|----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Elva J. Bitler                                       |   |  |  | 2. Date of Death<br>Month Day Year<br>July 11 1996 |  |  |  | 3. Time of Death<br>14:28                                |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Union Hospital of Cecil County |   |  |  | 4b. City, Town, or Location of Death<br>Elkton     |  |  |  | 4c. County of Death<br>Cecil                             |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| Funeral<br>Director   | 5. Social Security Number<br>164-20-2274   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>71 Yrs.          |  | 8. Date of Birth (Month, Day, Year)<br>February 26, 1925 |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
|   | Usual Residence of Decedent  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Cecil  |  | 10c. City, Town or Location<br>North East  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 10e. Street and Number<br>107 Caldwell Road   |  |   |  | 10f. Zip Code<br>21901   |  |  |  | 10g. Citizen of What Country?<br>United States   |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collega (1-4or 5+)<br>2  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Personnel Manager   |  |  |  | 16b. Kind of Business/Industry<br>Temporary Employment Service                                     |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 17. Father's Name (First, Middle, Last)<br>Robert Dollar  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Edna Henry  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Robert F. Bitler  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>107 Caldwell Road, North East, MD 21901   |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>North East Methodist Cem. 7/15/96  |  |  |  | 20c. Location - City or Town, State<br>North East, Maryland  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>Crouch Funeral Home<br>127 South Main Street, North East, MD 21901   |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| <table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>acute myocardial infarction in farcation</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td></td> <td>Due to (or as a consequence of):</td> <td>hours</td> </tr> <tr> <td></td> <td>CAF</td> <td></td> </tr> <tr> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td>Anoxic Encephalopathy</td> <td>5 months</td> </tr> <tr> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> |  |   |  |  |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | acute myocardial infarction in farcation | Approximate Interval Between Onset and Death |  | Due to (or as a consequence of): | hours |  | CAF |  |  | Due to (or as a consequence of): |  |  | Anoxic Encephalopathy | 5 months |  | Due to (or as a consequence of): |  |
| Immediate Cause (Final disease or condition resulting in death)   | acute myocardial infarction in farcation   | Approximate Interval Between Onset and Death  |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
|   | Due to (or as a consequence of):   | hours   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
|   | CAF  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
|   | Due to (or as a consequence of):   |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
|   | Anoxic Encephalopathy  | 5 months  |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
|   | Due to (or as a consequence of):   |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 28a. Date of Injury (Month, Day, Year)  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 28b. Time of Injury<br>M  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 28d. Describe how injury occurred   |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 29b. Signature and title of certifier<br>  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 29c. License number<br>D32395   |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 29d. Date signed (Month, Day, Year)<br>7-12-96  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Thomas Finucan, M.D., 3 Mauldin Avenue, North East, MD 21901 410-287-6616   |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 15 1996  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |
| 32. Registrar's Signature<br>  |  |   |  |  |  |  |  |  |  |   |  |  |  |                                  |       |  |     |  |  |                                  |  |  |                       |          |  |                                  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21862

## Certificate of Death

Reg. No.

|   |  |                                  |   |  |  |  |  |  |   |  |
|---|--|----------------------------------|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LEWIS FRANKLIN BURCH</b>                      |                                  |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>July 11 1996</b>                        |  | 3. Time of Death<br><b>4:00 P.M.</b>                        |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Mary's Hospital</b> |                                  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>                       |  | 4c. County of Death<br><b>St. Mary's</b>                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-36-5533</b>  |                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug 13, 1910</b>                       |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|   | Usual Residence of Decedent  |                                  |   |  |  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>St. Mary's</b> |   | 10c. City, Town or Location<br><b>Mechanicsville</b>   |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>4320 Waldorf Leonardtown Road</b>  |  |                                  |   | 10f. Zip Code<br><b>20659</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b>   |  |                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b> |  |  | 16b. Kind of Business/Industry<br><b>Farm</b>                                    |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Joseph Edwin Burch</b>  |  |                                  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beattie Knott</b>  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph F. Burch, Sr.</b>   |  |                                  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4155 Waldorf Leonardtown Rd., Mechanicsville, MD 20659</b>                                   |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Joseph Cemetery</b>  |  |  | Data<br><b>7/16/96</b>   |  | 20c. Location - City or Town, State<br><b>Morganza, MD</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael H. Gardiner</i>   |  |                                  |   |  |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Chronic Renal failure</i><br>Due to (or as a consequence of):<br>b. <i>Coronary Artery disease</i><br>Due to (or as a consequence of):<br>c. <i>ASCD</i><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><br><i>Y125</i><br><i>Y25</i><br><i>Y25</i> |  |                                  |   |  |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |   |  |
|   |  |                                  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |                                  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
|   |  |                                  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                  |   |  |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>William D. Boyd II</i>  |  |                                  |   |  |  | 29c. License number<br><b>214285</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7-12-96</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William D. Boyd II, M.D., Leonardtown, Md</b>  |  |                                  |   |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 16 1996</b>   |  |                                  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21863

## Certificate of Death

Reg. No.

|  |  |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
|--|--|---|---|--|---|--|--|--|---|---|----|---------------------------------|---|----|---|----|--|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Wilson G. Crowe</b>                 |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>1</b> Year <b>1996</b> |  |  |  | 3. Time of Death<br><b>3:00AM</b>                           |   |    |                                 |   |    |   |    |  |    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>The Pines</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>               |  |  |  | 4c. County of Death<br><b>Talbot</b>                        |   |    |                                 |   |    |   |    |  |    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-22-7566</b>                                    |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.                    |  | 8. Date of Birth (Month, Day, Year)<br><b>04/22/19</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |    |                                 |   |    |   |    |  |    |  |
|  | Usual Residence of Decedent  |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Caroline</b>  |   | 10c. City, Town or Location<br><b>Federalsburg</b>   |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |    |                                 |   |    |   |    |  |    |  |
| 10e. Street and Number<br><b>215 Maple Avenue</b>  |  |   |   | 10f. Zip Code<br><b>21632</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>                            |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |   |    |                                 |   |    |   |    |  |    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>  |   |  |  | 16b. Kind of Business/Industry<br><b>Lumber Company</b>  |   |   |    |                                 |   |    |   |    |  |    |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry George Crow</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Naomi Lena Mae Faulkner Crow</b>   |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carmon F. Crowe</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>215 Maple Ave., Federalsburg, MD 21632</b>   |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cambridge Crematory</b>   |   | Date<br><b>7/1/96</b>  |  | 20c. Location - City or Town, State<br><b>Cambridge, MD</b>                                    |   |   |    |                                 |   |    |   |    |  |    |  |
| 21. Signature of Funeral Service Licensee<br><b>Michael F. Eskow</b>   |  |   |   | 22. Name and Address of Facility<br><b>Frampton-Hawkins-Eskow Funeral Home<br/>P.O. Box 43, Federalsburg, MD 21632</b>   |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Congestive heart failure</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>1-2 months</b><br/><br/> <b>years</b> </td> </tr> <tr> <td>b.</td> <td><b>Atherosclerotic cardiovascular disease</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |   |   |  |   |  |  |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Congestive heart failure</b> | Approximate Interval Between Onset and Death<br><br><b>1-2 months</b><br><br><b>years</b> | b. | <b>Atherosclerotic cardiovascular disease</b> | c. |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.   | <b>Congestive heart failure</b>   | Approximate Interval Between Onset and Death<br><br><b>1-2 months</b><br><br><b>years</b> |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
|  | b.   | <b>Atherosclerotic cardiovascular disease</b>   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
|  | c.   |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
|  | d.   |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiac arrhythmias</b>   |  |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |   |    |                                 |   |    |   |    |  |    |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><b>MD Cronley</b>  |   | 29c. License number<br><b>D25933</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>7.1.96</b>                             |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MD Cronley, 508 Idlewild Avenue, Easton, MD 21601</b>   |  |   |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL - 2 '96</b>  |  | 32. Registrar's Signature<br><b>Sasha Davidson-Randall</b>  |   |  |   |  |  |  |   |   |    |                                 |   |    |   |    |  |    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

... ..

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21864

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>HILDEGARDE C. CLARK</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 1 1996</b>  |  | 3. Time of Death<br><b>7:10 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Washington Adventist Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>  |  | 4c. County of Death<br><b>Prince Georges</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>118-18-7699</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 9, 1920</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>15100 Interlachen Drive, Spt. 410</b>  |  | 10f. Zip Code<br><b>20906</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dental Assistant</b>  |  | 16b. Kind of Business/Industry<br><b>Dental</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles Hein</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dora Oertel</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert S. Clark</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20906</b><br><b>15100 Interlachen Dr. Apt. 410, Silver Spring, MD</b>                            |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Date<br><b>7/5/96</b>  |  | 20d. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Robert E Ramsey</i>  |  |   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.</b><br><b>500 University Blvd. W. Silver Spring, MD 20901</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>MYOCARDIAL INFARCTION</b><br><br>Due to (or as a consequence of):<br><b>CORONARY ARTERY DISEASE</b><br><br>Due to (or as a consequence of):<br><br><br>Due to (or as a consequence of):<br><br><br>Due to (or as a consequence of):<br><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br><b>1 DAY</b>  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   |  |  |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br><i>Patricia A Gurny, MD</i>   |  | 29c. License number<br><b>D263 44</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7-5-96</b>  |  |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Patricia A. Gurny M.D. 7600 Carroll Avenue Takoma Park, Maryland 20912</b>  |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21865

## Certificate of Death

Reg. No.

|   |  |  |   |                                |  |
|---|--|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>GERTRUDE H. CUSACK</b>  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>10</b> Year <b>1996</b>  |                                | 3. Time of Death<br><b>12:18A.M.</b>   |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>  |                                | 4c. County of Death<br><b>MONTGOMERY</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>272-34-1999</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>July 11, 1907</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>   |                                |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent  |  |   |                                |  |
|   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Bethesda</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>6017 Henning Street</b>   |  | 10f. Zip Code<br><b>20817</b>   |                                | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>  |                                |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Practical Nurse</b>  |  | 16b. Kind of Business/Industry<br><b>Hospital</b>   |                                |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Thomas Vesey</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Fleming</b>   |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Paschal/daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8521 Pelham Road, Bethesda, Maryland 20817</b>  |                                |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Calvary Cemetery</b>   |                                | 20c. Location - City or Town, State<br><b>Youngstown, Ohio</b>   |
|   | 21. Signature of Funeral Service Licensee<br><b>Robert A. Pumphrey</b> M00198  |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>   |                                |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |                                | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONGESTIVE HEART FAILURE</b>  |  |   |                                | <b>YEARS</b>   |
|   | Due to (or as a consequence of):<br><b>b. UROSEPSIS</b>  |  |   |                                | <b>1 DAY</b>   |
|   | Due to (or as a consequence of):<br><b>c. DIABETES MELLITUS</b>  |  |   |                                | <b>YEARS</b>   |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred   |                                |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|   | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |                                |  |
|   | 29b. Signature and title of certifier<br><b>Kana Hudson, MD</b>  |  | 29c. License number<br><b>D41866</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>JULY 10 1996</b>   |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>KANAN HUDHUB, MD 481 N. FREDERICK AVE #231 GAITHERSBURG, MD 20877</b>   |  |   |                                |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>  |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21866

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |  |   |  |         |  |          |  |  |  |  |
|--|---|---|--|--|--|--|--|---|--|---------|--|----------|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ALEEN M. COOLEY</b>                          |   |  |  | 2. Date of Death<br>Month Day Year<br><b>July 10, 1996</b> |  | 3. Time of Death<br><b>3:10PM</b>                          |   |  |         |  |          |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6014 Melvern Drive</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>    |  | 4c. County of Death<br><b>Montgomery</b>                   |   |  |         |  |          |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-24-4398</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>May 27, 1926</b> |   |  |         |  |          |  |  |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                 |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>                           |  | 10c. City, Town or Location<br><b>Bethesda</b>             |   |  |         |  |          |  |  |  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>6014 Melvern Drive</b>   |  | 10f. Zip Code<br><b>20817</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |  |         |  |          |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |         |  |          |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> Collage (1-4or 5+) <input checked="" type="checkbox"/> 5+  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>  |  | 16b. Kind of Business/Industry<br><b>Hospital</b>  |  |  |  |   |  |         |  |          |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Melvin Jacob Rhoades</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Payton</b>  |  |  |  |   |  |         |  |          |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Theresa C. Cooley-Zgela/daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6014 Melvern Drive, Bethesda, Maryland 20817</b>   |  |  |  |   |  |         |  |          |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Arlington, Virginia</b>  |  | 20d. Date<br><b>July 17, 1996</b>  |  |   |  |         |  |          |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>David E. Perry</b>   |   | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/<br/>Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue<br/>Bethesda, Maryland 20814-3501</b>  |  |  |  |  |  |   |  |         |  |          |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |  |  |   |  |         |  |          |  |  |  |  |
| <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>SEPTIC SHOCK</b><br/>Due to (or as a consequence of):</td> <td>12 days</td> </tr> <tr> <td>b. <b>RHEUMATOID ARTHRITIS</b><br/>Due to (or as a consequence of):</td> <td>20 YEARS</td> </tr> <tr> <td>c. <br/>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. <br/>Due to (or as a consequence of):</td> <td></td> </tr> </table> |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <b>SEPTIC SHOCK</b><br>Due to (or as a consequence of): | 12 days | b. <b>RHEUMATOID ARTHRITIS</b><br>Due to (or as a consequence of): | 20 YEARS | c.<br>Due to (or as a consequence of): |  | d.<br>Due to (or as a consequence of): |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | a. <b>SEPTIC SHOCK</b><br>Due to (or as a consequence of):                                  | 12 days   |  |  |  |  |  |   |  |         |  |          |  |  |  |  |
|  | b. <b>RHEUMATOID ARTHRITIS</b><br>Due to (or as a consequence of):                          | 20 YEARS  |  |  |  |  |  |   |  |         |  |          |  |  |  |  |
|  | c.<br>Due to (or as a consequence of):  |   |  |  |  |  |  |   |  |         |  |          |  |  |  |  |
|  | d.<br>Due to (or as a consequence of):  |   |  |  |  |  |  |   |  |         |  |          |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |         |  |          |  |  |  |  |
|  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |         |  |          |  |  |  |  |
|  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |         |  |          |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |         |  |          |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |         |  |          |  |  |  |  |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |         |  |          |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |  |  |   |  |         |  |          |  |  |  |  |
| 29b. Signature and title of certifier<br><b>David E. Perry, MD</b>   |   | 29c. License number<br><b>D-28953</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7-11-96</b>  |  |  |  |   |  |         |  |          |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>P. HIRSZEL, MD</b>  |   |   |  | 32. Registrar's Signature<br><b>Julia Davidson-Rodriguez</b>   |  |  |  |   |  |         |  |          |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>  |   |   |  |  |  |  |  |   |  |         |  |          |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

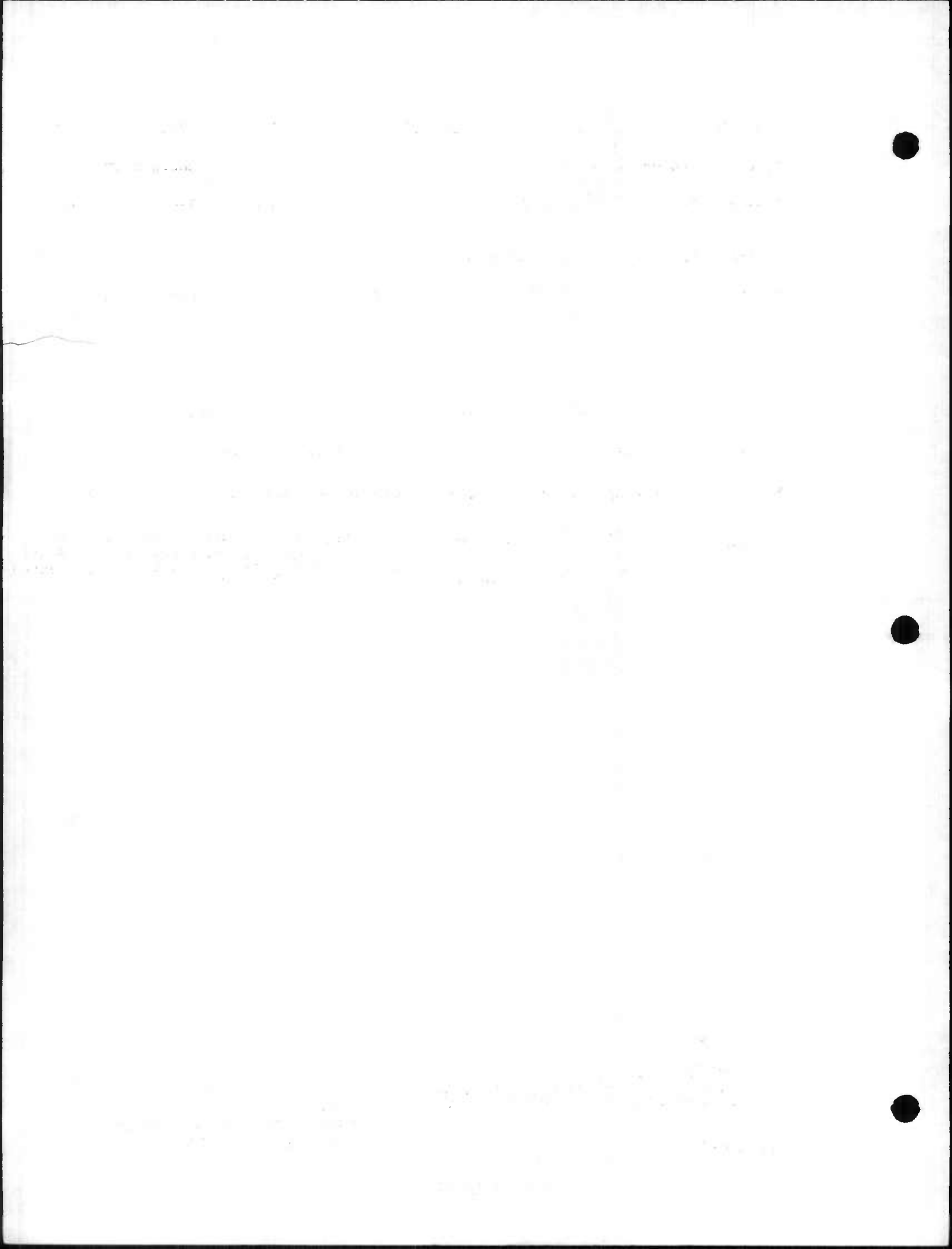
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21867

## Certificate of Death

Reg. No.

|   |   |   |   |  |   |  |  |  |                                     |   |
|---|---|---|---|--|---|--|--|--|-------------------------------------|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Giovanna Caponiti                   |   |   |  | 2. Date of Death<br>Month July Day 6 Year 1996  |  |  |  | 3. Time of Death<br>4:00 PM         |   |
|   | 4a. Facility Name (If not Institution, give street end number)<br>802 Dale Road |   |   |  | 4b. City, Town, or Location of Death<br>Glen Burnie   |  |  |  | 4c. County of Death<br>Anne Arundel |   |
| Funeral<br>Director   | 5. Social Security Number<br>579-44-9967  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>100 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>May 14, 1896                                  |  | 9. Birthplace (State or Foreign Country)<br>Italy  |                                     |   |
|   | Usual Residence of Decedent   |   |   |  |   |  |  |  |                                     |   |
| 10a. State<br>Maryland  |   | 10b. County<br>Anne Arundel   |   | 10c. City, Town or Location<br>Glen Burnie   |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                     |   |
| 10e. Street and Number<br>802 Dale Road   |   |   |   | 10f. Zip Code<br>21060   |   | 10g. Citizen of What Country?<br>USA   |  |  |                                     |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |                                     |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) N/A College (1-4or 5+) College (1-4or 5+)  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |   |  | 16b. Kind of Business/Industry<br>Own Home                       |  |                                     |   |
| 17. Father's Name (First, Middle, Last)<br>Melchiorre Puglisi   |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dominica Unobtainable  |  |  |  |                                     |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Joanne Caponiti / Granddaughter   |   |   |   |  | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)<br>802 Dale Road, Glen Burnie, Maryland 21060 |  |  |  |                                     |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery |  | Date<br>7/10/96   |  | 20c. Location - City or Town, State<br>Suitland, Maryland        |  |                                     |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |   |  | 22. Name and Address of Facility<br>Hines-Rinaldi Funeral Home<br>11800 New Hampshire Avenue<br>Silver Spring, Maryland 20904               |  |  |  |                                     |   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |   |  |  |  |                                     | Approximate Interval Between Onset and Death  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial infarction<br>Due to (or as a consequence of):<br>b. Coronary artery disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.   |   |   |   |  |   |  |  |  |                                     | 1 day<br>3 yrs  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   |  |  |  |                                     | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |   |  |  |  |                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |                                     |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |                                     |   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>Gregory A. Caponiti MD   |   |  |   |  |  |  |                                     |   |
| 29c. License number<br>D24942   |   | 29d. Date signed (Month, Day, Year)<br>July 9 1996  |   |  |   |  |  |  |                                     |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gregory A. Caponiti MD 5317 Cherry Lane   |   |   |   |  |   |  |  |  |                                     |   |
| 31. Date filed (Month, Day, Year)<br>JUL 12 1996  |   | 32. Registrar's Signature<br>John Davidson-Randall  |   |  |   |  |  |  |                                     |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

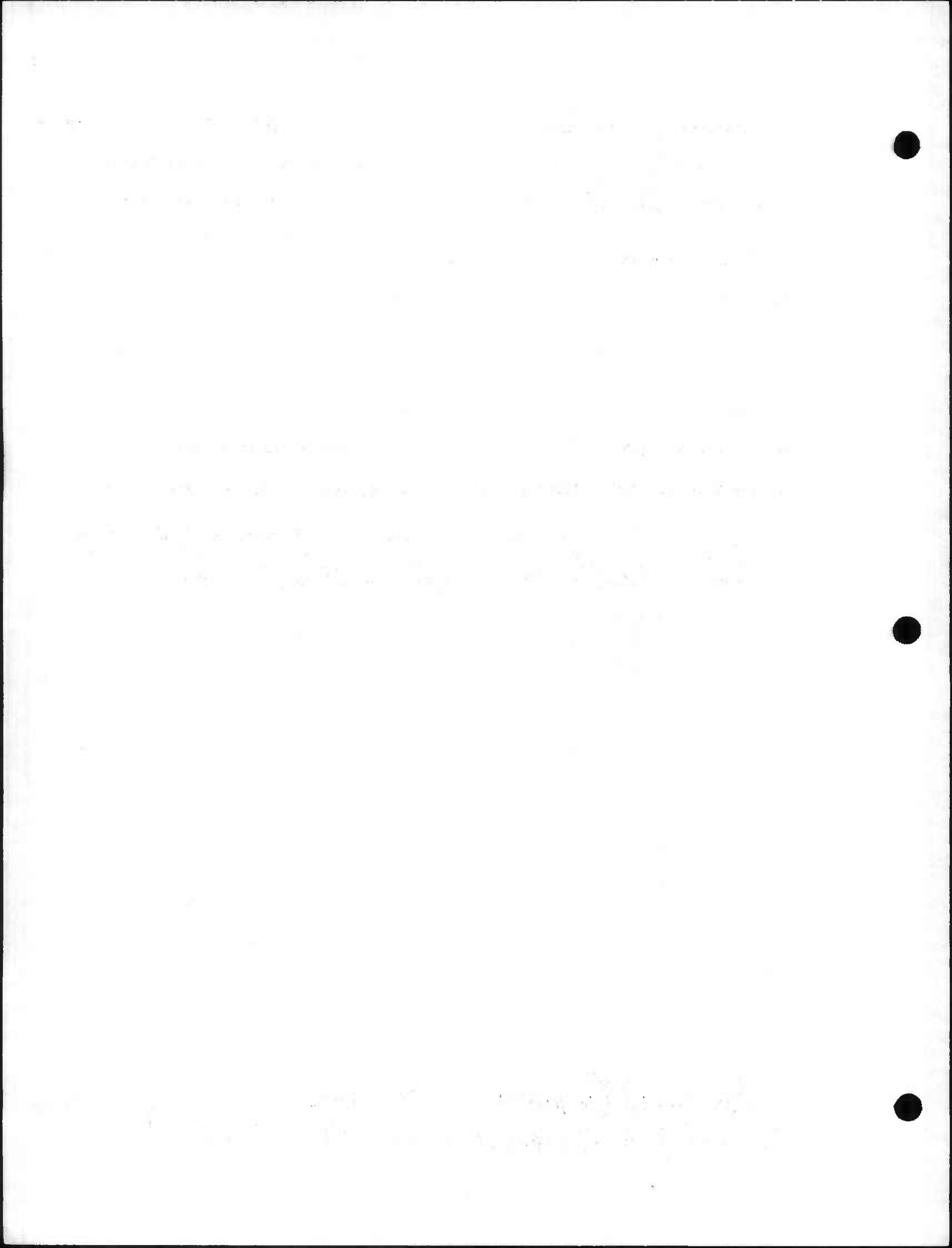
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21868

Amended #8, 7/9/96, MRT, Montg. Cty. Certificate of Death

Reg. No.

|   |   |  |   |   |   |                                |  |  |
|---|---|--|---|---|---|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>John Paul Corless   |  |   |   | 2. Date of Death<br>Month Day Year<br>July 5, 1996  |                                | 3. Time of Death<br>8:10 pm  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital   |  |   |   | 4b. City, Town, or Location of Death<br>Silver Spring   |                                | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director   | 5. Social Security Number<br>171-07-5311  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>88 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>Nov. 3, 1996                                  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |
|   | Usual Residence of Decedent<br>10a. State MD 10b. County Montgomery 10c. City, Town or Location Silver Spring 10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |   |                                |  |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br>3553 South Leisure World Blvd. #2C  |  |   |   | 10f. Zip Code<br>20906  |                                | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Pharmacist   |   | 16b. Kind of Business/Industry<br>Pharmacy  |                                |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>William Corless  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Amelia Erwin   |                                |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>John Paul Corless, Jr.  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14522 Woodcrest Drive, Rockville, MD 20853-2370  |                                |  |  |
| Physician<br>/Medical<br>Examiner   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Cemetery   |   | Data<br>7/7/96  |                                | 20c. Location - City or Town, State<br>Alexandria, Virginia                          |  |
|   | 21. Signature of Funeral Service Licensee<br>Timothy J. Campbell  |  |   |   | 22. Name and Address of Facility<br>Francis J. Collins Funeral Home, Inc. 500 University Boulevard West, Silver Spring, MD 20901  |                                |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. mesenteric ischemia<br>Due to (or as a consequence of):<br>b. peripheral vascular disease<br>Due to (or as a consequence of):<br>c. C. difficile colitis<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |                                |  | Approximate Interval Between Onset and Death<br>days<br>years  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Prostate cancer<br>RESPIRATORY FAILURE  |  |   |   |   |                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |   |                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |                                |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred   |                                |  |  |
|   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |                                |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier   |   | 29c. License number<br>D36046   |                                | 29d. Date signed (Month, Day, Year)<br>7/6/96  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JOHN J. MENDOZA JR MD |   | 31. Date filed (Month, Day, Year)<br>JUL 09 1996 |   |   |   |                                |  |  |
| 32. Registrar's Signature<br>John Davidson-Randall  |   | 33. Date filed (Month, Day, Year)<br>JUL 09 1996 |   |   |   |                                |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21869

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Mabel L. Carnes

2. Date of Death

Month Day Year  
July 8, 1996

3. Time of Death

9:45 AM

4a. Facility Name (If not institution, give street and number)

Althea Woodland Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

218-46-0918

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 2, 1898

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Mt. Rainier

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3108 Perry Street

10f. Zip Code

20712

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Addison McKimney

18. Mother's Name (First, Middle, Maiden Surname)

Rosalie Apple

19a. Informant's Name/Relationship (Type, Print)

Raymond E. Carnes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Christopher Street New York, New York 10014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

7/11/96

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Sil. Spr., MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. aspiration

Due to (or as a consequence of):

48 hr.

c. poor esophageal function

Due to (or as a consequence of):

(weak muscles)

Many months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D17423

29d. Date signed (Month, Day, Year)

7/9/96 11:55 AM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah B. Goldberg, M.D. 8700 Georgia Avenue #400 Silver Spring, Maryland 20910

31. Date filed (Month, Day, Year)

JUL 11 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21870

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Ross Lee Caudill</u>                                |   |  |  | 2. Date of Death<br>Month <u>July</u> Day <u>10</u> Year <u>1996</u> |  | 3. Time of Death<br><u>0710</u>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Harford Memorial Hospital</u> |   |  |  | 4b. City, Town, or Location of Death<br><u>Havre de Grace</u>        |  | 4c. County of Death<br><u>Harford</u>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>180-09-3993</u>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>87</u> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>April 5, 1909</u>                                    | 9. Birthplace (State or Foreign Country)<br><u>North Carolina</u>  |
|  | Usual Residence of Decedent  |   |  |  |  |  |  |  |
| 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Harford</u>   |  | 10c. City, Town or Location<br><u>Havre de Grace</u>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><u>113 Robin Hood Rd.</u>  |  |   |  | 10f. Zip Code<br><u>21078</u>  |  | 10g. Citizen of What Country?<br><u>USA</u>                                      |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>WWII</u>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>          |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Crane Operator</u>   |  | 18b. Kind of Business/Industry<br><u>US Government</u>                           |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>Rowan Floyd Caudill</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Sarah <del>Fannie</del> McBride</u>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>C. Bruce Caudill - Son</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>4226 Webster Rd., Havre de Grace, Md. 21078</u>  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Bel Air Memorial Gardens</u>   |  | Date<br><u>7-12-96</u>   |  | 20c. Location - City or Town, State<br><u>Bel Air, Maryland</u>                  |  |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>  |  |   |  | 22. Name and Address of Facility<br><u>Howard K. McComas III Funeral Home, P.A.<br/>50 W. Broadway St., Bel Air, Md. 21014</u>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <u>Cerebral</u><br>Due to (or as a consequence of):<br><br>b. <u>CHF</u><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>- IDDM</u><br><u>- CAD</u><br><u>- MI</u>   |  |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><u>[Signature]</u>   |  | 29c. License number<br><u>D42800</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>7/10/96</u>                            |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>T. Harold MS and 314 S. Union Ave, HLG, Md, 21078</u>   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><u>July 10 1996</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

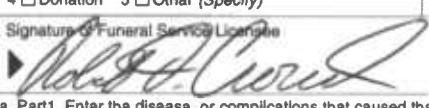
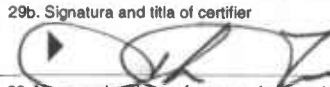
Division of Vital Records, P.O. Box 68760,



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 21871

Reg. No.

|  |   |  |   |  |  |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>David Franklin Carter, Sr.</b>                           |  |   |  |  |  | 2. Date of Death<br>Month <u>July</u> Day <u>9</u> Year <u>1996</u>              |  | 3. Time of Death<br><u>1200 P</u>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital of Cecil County</b> |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>                            |  | 4c. County of Death<br><b>Cecil</b>  |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>218-34-1529</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>February 23, 1940</b>                  |  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>                               |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |   |  | 10b. County<br><b>Cecil</b>   |  |  | 10c. City, Town or Location<br><b>Rising Sun</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>433 McGrady Road</b>  |   |  |   |  |  | 10f. Zip Code<br><b>21911</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>              |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)   |   |  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrician-Maintenance</b>  |  |  | 16b. Kind of Business/Industry<br><b>Plastics Manufacturer</b>                                 |  |
| 17. Father's Name (First, Middle, Last)<br><b>David L. Carter</b>  |   |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertie Delp</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Daniel K. Carter</b>  |   |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>433 McGrady Road, Rising Sun, Maryland 21911</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ebenezer Cemetery</b>  |  |  | Data<br><b>7/12/96</b>   |  | 20c. Location - City or Town, State<br><b>Rising Sun, Maryland</b> |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  |   |  |  | 22. Name and Address of Facility<br><b>Crouch Funeral Home<br/>127 South Main Street, North East, MD 21901</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><div style="display: flex; justify-content: space-between;"><div style="width: 80%;">a. <u>Myocardial infarction</u><br/>Due to (or as a consequence of):</div><div style="width: 15%;">Approximate Interval Between Onset and Death<br/><b>minutes</b></div></div><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><div style="display: flex; justify-content: space-between;"><div style="width: 80%;">b. _____<br/>Due to (or as a consequence of):</div><div style="width: 15%;"></div></div><br><div style="display: flex; justify-content: space-between;"><div style="width: 80%;">c. _____<br/>Due to (or as a consequence of):</div><div style="width: 15%;"></div></div><br><div style="display: flex; justify-content: space-between;"><div style="width: 80%;">d. _____<br/>Due to (or as a consequence of):</div><div style="width: 15%;"></div></div> |   |  |   |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |  |   |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |   |  | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  | 29b. Signature and title of certifier<br>  |  |  | 29c. License number<br><b>D32395</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/9/96</b>               |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas Finucan, M.D., 3 Mauldin Avenue, North East, MD 21901 410-287-6616</b>   |   |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 1996</b>  |   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21872

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles W. Cox, Sr.

2. Date of Death  
Month Day Year

07 14 96

3. Time of Death

0830 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Marys Hospital

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Marys

5. Social Security Number

577-03-9739

6. Sex

XX M ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

07-09-18

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

Rt. 2 Box 90

10f. Zip Code

20622

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Carpenter

18b. Kind of Business/Industry

Union/Carpenter

17. Father's Name (First, Middle, Last)

George Nalley Cox

18. Mother's Name (First, Middle, Maiden Surname)

Helen Elaine Berry

19a. Intormant's Name/Relationship (Type, Print)

Ronald N. Cox

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt. 2 Box 90, Charlotte Hall, MD 20622

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans' Cem.

Date

7-17-96

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensed

Mark G. Brohawn M00053

22. Name and Address of Facility

Huntt Funeral Home

P. O. Box 156, Waldorf, MD 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Acute cerebrovascular accident*

Due to (or as a consequence of):

Approximate interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Metastatic Carcinoma Colon*

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, tectory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19917

29d. Date signed (Month, Day, Year)

7/14/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES S. BOYD

BUSH WOOD

MARYLAND

31. Date filed (Month, Day, Year)

JUL 15 1996

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

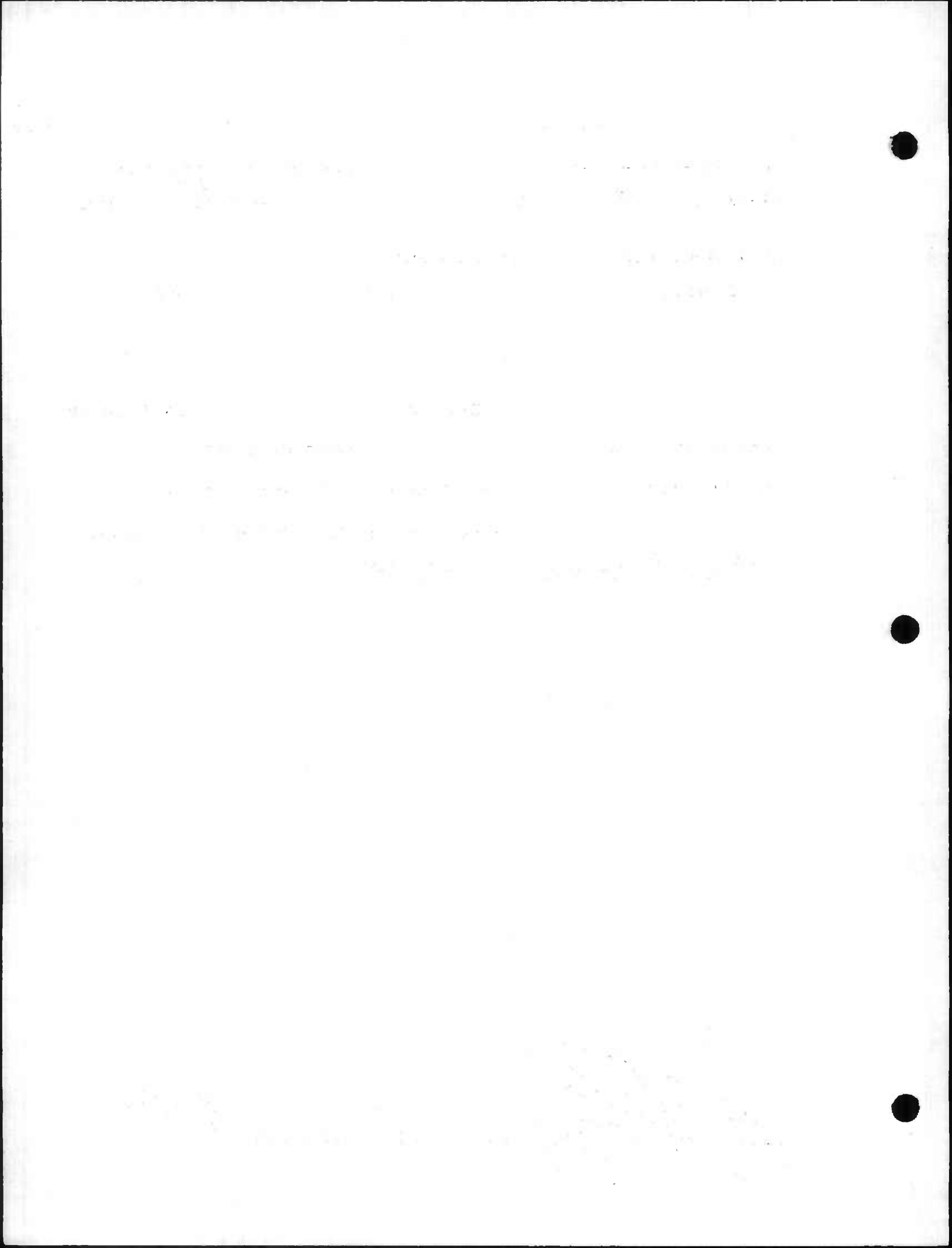
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2028.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



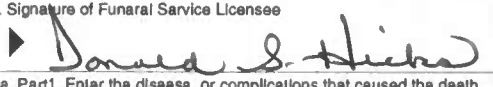

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

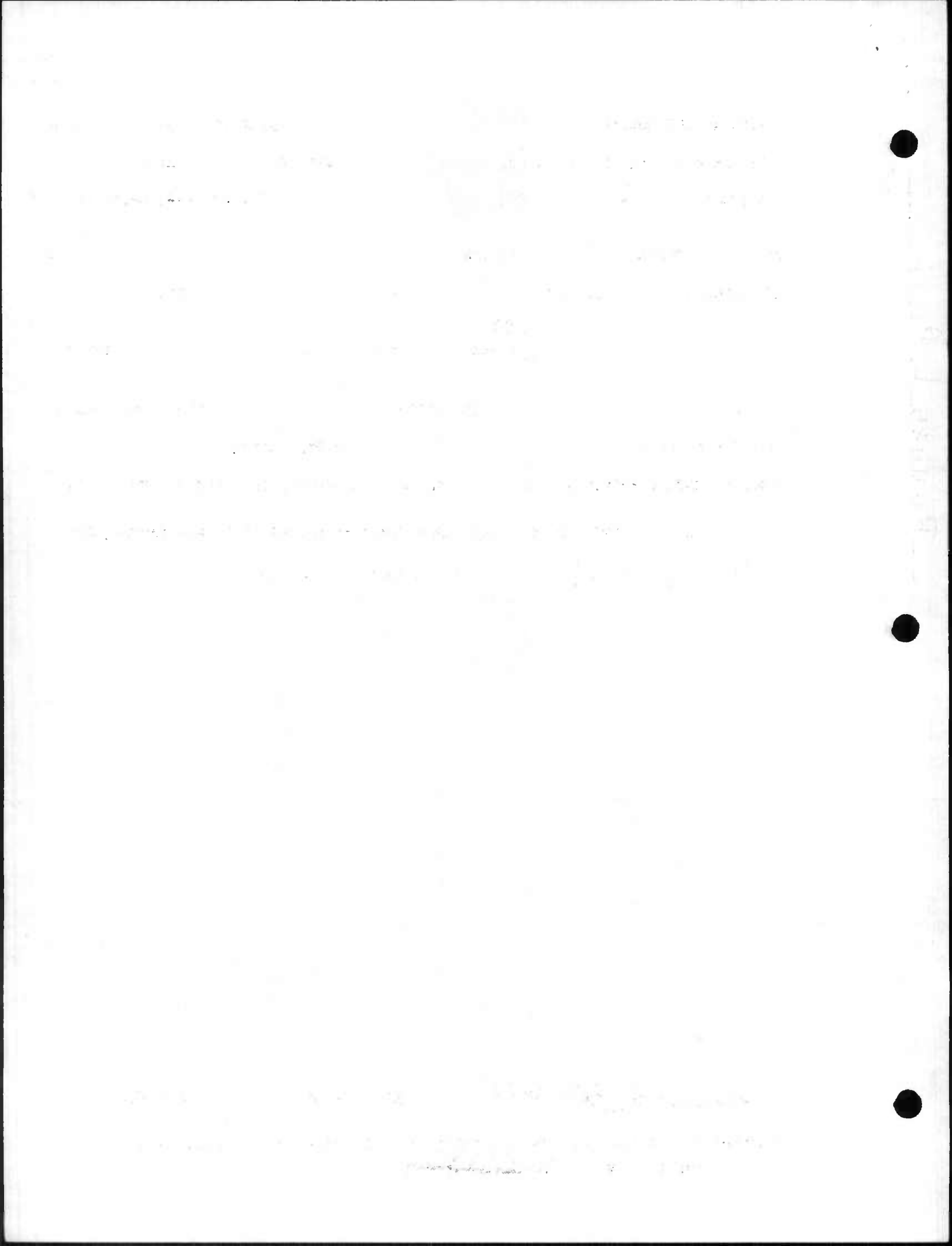
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21873

|  |   |  |   |  |  |   |   |  |  |  |
|--|---|--|---|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD LEE COLLINS</b>  |  |   |  |  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>12</b> Year <b>1996</b>                        |  | 3. Time of Death<br><b>8:15am</b>  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>757 JACKSON HALL SCHOOL ROAD</b>   |  |   |  |  |   | 4b. City, Town, or Location of Death<br><b>ELKTON</b>                                       |  | 4c. County of Death<br><b>CECIL</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>236-16-4269</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 22, 1918</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>BEECH FORK, KY</b>                              |  |
|  | Usual Residence of Decedent   |  |   |  |  |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>CECIL</b>   |  | 10c. City, Town or Location<br><b>ELKTON</b>   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>757 JACKSON HALL SCHOOL RD.</b>  |  |   |  | 10f. Zip Code<br><b>21921</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates: <b>01/12/46</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>INSPECTOR</b>   |  |  |   | 16b. Kind of Business/Industry<br><b>AUTO MANUFACTURING</b>                                 |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>TALMADGE COLLINS</b>  |  |   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BERTHA DIXON</b>                    |  |  |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>CAROL S. COOK (DAUGHTER)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>757 JACKSON HALL SCHOOL RD., ELKTON, MD 21921</b>  |   |   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>ENTOMBMENT</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GRACELAWN MEMORIAL PK.</b>   |  | Data<br><b>07/15/96</b>  |   | 20c. Location - City or Town, State<br><b>NEW CASTLE, DE</b>                                |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Hicks Home for Funerals<br/>103 W. Stockton St. Elkton, MD 21921</b>  |   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>ALZHEIMER'S DISEASE</b><br>Due to (or as a consequence of):<br>b. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br>c. <b>ATHEROSCLEROTIC HEART DISEASE</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><br>5 YRS.<br>10 YRS.<br>10 YRS. |  |   |  |  |   |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>N/A</b>  |  |   |  |  |   |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |   |   |  |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |   |   |  |  |  |
| 29b. Signature and Title of certifier<br>   |   |  |   | 29c. License number<br><b>DC 664</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/12/96</b> |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael B. Peters, M.D. 1941 Limestone Road Wilmington, Delaware 19808</b>  |   |  |   |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 15 1996</b>  |   |  |   | 32. Registrar's Signature<br> |  |   |   |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

96 21874

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |   |  |  |  |  |  |
|---|---|---|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Joseph Elwood Cusic Jr.                           |   |  |  | 2. Date of Death<br>Month Day Year<br>July 9, 1996 |   |  |  | 3. Time of Death<br>6:20pm                     |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Physician Memorial Hospital |   |  |  | 4b. City, Town, or Location of Death<br>La Plata   |   |  |  | 4c. County of Death<br>Charles                 |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-38-3402  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>57 Yrs.          |   | 8. Date of Birth (Month, Day, Year)<br>April 7, 1939 |  | 9. Birthplace (State or Foreign Country)<br>MD |  |  |
|   | Usual Residence of Decedent   |   |  |  |  |   |  |  |  |  |  |
| 10a. State<br>MD  |   | 10b. County<br>Charles Co.  |  | 10c. City, Town or Location<br>LaPlata   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br>P.O. Box 206 10455 LaPlata Road   |   |   |  | 10f. Zip Code<br>20646   |  |   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales   |  |   |  | 16b. Kind of Business/Industry<br>Shoes  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Joseph Elwood Cusic, Sr.   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elvie Ann Wood  |  |   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Arleen A. Cusic/Spouse  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 206 10455 LaPlata Rd. LaPlata MD 20646   |  |   |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Queen of Peace  |  | 20c. Location - City or Town, State<br>7/12/96 Helen, MD   |  |   |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael L. Gardiner</i>   |   |   |  | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270 Leonardtown, MD 20650   |  |   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cerebrus</i><br>Due to (or as a consequence of):<br>b. <i>Hepatorenal failure</i><br>Due to (or as a consequence of):<br>c. <i>ascites</i><br>Due to (or as a consequence of):<br>d. <i>alcohol abuse</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>3 days |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Bilateral pleural effusions</i><br><i>Hepatic encephalopathy, gnotemia</i>   |   |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Paul Pritchett MD</i>   |   |   |  | 29c. License number<br>D - 08370   |  |   |  | 29d. Date signed (Month, Day, Year)<br>7/9/96  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Pritchett, Paul, MD 118 La Grange Ave., P.O. Box 1317 La Plata MD 20646   |   |   |  |  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)   |   |   |  | 32. Registrar's Signature<br>▶   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 21875

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Theresa Fay Clements</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 13, 1996</b>   |  | 3. TIME OF DEATH<br><b>08:58 a. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-42-6146</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>December 22, 1932</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Mary's Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Leonardtown</b>  |  | 9c. COUNTY OF DEATH<br><b>St. Mary's</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>St. Mary's</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Leonardtown</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>Route 2, Box 86-D</b>  |  |  |  | 10f. ZIP CODE<br><b>20650</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>n/a</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Simpson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Blanche Cole</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles G. Clements</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Route 2, Box 86-D, Leonardtown, Maryland 20650</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                 |  | DATE<br><b>July 15, 1996</b>   |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, Virginia</b>                                  |  |
| 21. SIGNATURE OF FUNERAL HOME LICENSEE<br><br><b>Michael K. Blankenship, M00857</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Brinsfield Funeral Home, P.A.<br/>59 N. Washington St., Leonardtown, MD 20650-0279</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Melanotic Breast Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>2 yrs</b> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                   |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28e. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>James C. Boyd, M.D., 115 Washington Street, Leonardtown, Maryland 20650</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James C. Boyd, M.D., 115 Washington Street, Leonardtown, Maryland 20650</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D19917</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/13/96</b>   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 16 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Ellen Countiss  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 16, 1996   |  | 3. TIME OF DEATH<br>2:00 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-90-6692   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>79 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug 30, 1916  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>77 Coral Place  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Lexington Park  |  |
| 9c. COUNTY OF DEATH<br>St. Mary's  |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>St. Mary's  |  |
| 10c. CITY, TOWN OR LOCATION<br>Lexington Park  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>77 Coral Place   |  |
| 10f. ZIP CODE<br>20653   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7th Grade<br>College (1-4 or 5+) College  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph O. Curtis  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rose Cole  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mary L. Martin   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>77 Coral Place, Lexington Park, MD 20653   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Immaculate Heart of Mary 7/19/96   |  | 20c. LOCATION — City or Town, State<br>Lexington Park, MD  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael J. Gardiner</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory failure -</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Dehydration &amp; poor intake -</i> 2 days<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Left CVA &amp; Rt. Hemiplegia - X5 yrs -</i> 5 yr<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>Parkinson's disease -</i> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Rita B. Jhaveri</i>  |  |  |  | 29c. LICENSE NUMBER<br>D32651   |  | 29d. DATE SIGNED (Month, Day, Year)<br>7/17/96   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Rita Jhaveri, M.D. 100 Exploration Bldg, Lexington Park, MD 20653   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 18 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21877

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |
|---|---|---|---|--|--|--|--|--|---|----|---------------------|--|----|------|----|--|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>GENE Aloysius CUSIC Sr.   |   |   |  | 2. Date of Death<br>Month Day Year<br>July 15 1996   |  | 3. Time of Death<br>9:00 A.M.  |  |   |    |                     |  |    |      |    |  |    |
|   | 4e. Facility Name (If not institution, give street and number)<br>St. Mary's Hospital   |   |   |  | 4b. City, Town, or Location of Death<br>Leonardtwn   |  | 4c. County of Death<br>St. Mary's  |  |   |    |                     |  |    |      |    |  |    |
| Funeral<br>Director   | 5. Social Security Number<br>215-52-8049  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>48 Yrs.   | If Under 1 Year<br>Months Days                 | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>June 16, 1948   |  | 9. Birthplace (State or Foreign Country)<br>Maryland |   |    |                     |  |    |      |    |  |    |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |
| To Be Completed by Funeral Director   | 10a. State<br>MD  | 10b. County<br>St. Marys  |   | 10c. City, Town or Location<br>Hollywood       |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |    |                     |  |    |      |    |  |    |
|   | 10e. Street and Number<br>Rt. 2 Box 532   |   |   | 10f. Zip Code<br>20636                         |  | 10g. Citizen of What Country?<br>USA   |  |  |   |    |                     |  |    |      |    |  |    |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |   |    |                     |  |    |      |    |  |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4or 5+)  |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Plumber                              |  |  | 16b. Kind of Business/Industry<br>Plumbing   |  |  |   |    |                     |  |    |      |    |  |    |
|   | 17. Father's Name (First, Middle, Last)<br>James Carroll Cusic  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Gertrude Bernadine Hall   |  |  |  |   |    |                     |  |    |      |    |  |    |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Gene Aloysius Cusic, Jr/Son   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rt 2 Box 532 Hollywood, MD 20636  |  |  |  |   |    |                     |  |    |      |    |  |    |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. John's Cemetery   |  | Date<br>7/19/96  |  | 20c. Location - City or Town, State<br>Hollywood, MD   |  |   |    |                     |  |    |      |    |  |    |
|   | 21. Signature of Funeral Service Licensee<br><i>Michael H. Gardiner</i>   |   |   |  | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650  |  |  |  |   |    |                     |  |    |      |    |  |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |
|   | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Respiratory Failure</td> <td rowspan="4">Approximate interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>COPD</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. | Respiratory Failure | Approximate interval Between Onset and Death | b. | COPD | c. |  | d. |
| Immediate Cause (Final disease or condition resulting in death)   | a.  | Respiratory Failure   | Approximate interval Between Onset and Death  |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |
|   | b.  | COPD  |   |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |
|   | c.  |   |   |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |
|   | d.  |   |   |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |   |    |                     |  |    |      |    |  |    |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |    |                     |  |    |      |    |  |    |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |    |                     |  |    |      |    |  |    |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of injury<br>M                       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |    |                     |  |    |      |    |  |    |
|   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred              |  |  |  |  |   |    |                     |  |    |      |    |  |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><i>Dr. William Boyd</i>  |   |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |
|   |   | 29c. License number<br>D14285   |   | 29d. Date signed (Month, Day, Year)<br>7-15-96 |  |  |  |  |   |    |                     |  |    |      |    |  |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. WILLIAM BOYD LEONARDTOWN, Md. 20650   |   |   |   |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |
| 31. Date filed (Month, Day, Year)<br>JUL 18 1996  |   | 32. Registrar's Signature<br><i>John Davidson Randall</i>   |   |  |  |  |  |  |   |    |                     |  |    |      |    |  |    |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used in the study.

3. The third part is a discussion of the results of the study.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a list of figures and tables.

6. The sixth part is a list of appendices.

7. The seventh part is a list of footnotes.

8. The eighth part is a list of symbols and abbreviations.

9. The ninth part is a list of acknowledgments.

10. The tenth part is a list of references.

11. The eleventh part is a list of figures and tables.

12. The twelfth part is a list of appendices.

13. The thirteenth part is a list of footnotes.

14. The fourteenth part is a list of symbols and abbreviations.

15. The fifteenth part is a list of acknowledgments.

16. The sixteenth part is a list of references.

17. The seventeenth part is a list of figures and tables.

18. The eighteenth part is a list of appendices.

19. The nineteenth part is a list of footnotes.

20. The twentieth part is a list of symbols and abbreviations.

21. The twenty-first part is a list of acknowledgments.

22. The twenty-second part is a list of references.

23. The twenty-third part is a list of figures and tables.

24. The twenty-fourth part is a list of appendices.

25. The twenty-fifth part is a list of footnotes.

26. The twenty-sixth part is a list of symbols and abbreviations.

27. The twenty-seventh part is a list of acknowledgments.

28. The twenty-eighth part is a list of references.

29. The twenty-ninth part is a list of figures and tables.

30. The thirtieth part is a list of appendices.

31. The thirty-first part is a list of footnotes.

32. The thirty-second part is a list of symbols and abbreviations.

33. The thirty-third part is a list of acknowledgments.

34. The thirty-fourth part is a list of references.

35. The thirty-fifth part is a list of figures and tables.

36. The thirty-sixth part is a list of appendices.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21878

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |   |  |  |
|---|--|--|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>SHIRLEAN ROSETTA CALHOUN   |  |   |  | 2. Date of Death<br>Month JULY Day 5, Year 1996   |   | 3. Time of Death<br>14:00 PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE CITY  |   | 4c. County of Death  |  |
| Funeral<br>Director   | 5. Social Security Number<br>216-70-9509   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>47 Yrs.                  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Birth<br>(Month, Day, Year)<br>9/12/48  | 9. Birthplace (State or Foreign Country)<br>MD |
|   | Usual Residence of Decedent  |  |   |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD   |  | 10b. County<br>St. Marys  |  | 10c. City, Town or Location<br>Lexington Park   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>P.O. Box 254, 9 Brighton Ave.  |  |   |  | 10f. Zip Code<br>20653  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4or 5+) 10  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Day Care Provider  |   | 16b. Kind of Business/Industry<br>Child Care   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Ernest Webster Dyson  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Amanda Lucille Barnes  |   |  |  |
| Physician<br>/Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>James T. Calhoun/Spouse  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 254, 9 Brighton Ave., Lexington Park, MD 20653  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Charles Memorial  |  | 20c. Location - City or Town, State<br>Leonardtwn   |   | 20d. Date<br>7/10/96   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Michael L. Gardiner</i>  |  |   |  | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650   |   |  |  |
|   | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Sepsis Due to (or as a consequence of):<br>b. Hepatic Failure Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>3 days<br>5 years |  |   |  |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |   |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Cardiac Tamponade<br>Renal Failure   |  |   |  |   |   |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|   | 28d. Describe how injury occurred  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>J. A. Underwood, MD</i>   |  |  |   | 29c. License number<br>M6175                               |   | 29d. Date signed (Month, Day, Year)<br>July 5, 1996 |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>J. A. UNDERWOOD, MD JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND  |  |  |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL - 8 1996   |  |  |   | 32. Registrar's Signature<br><i>Jahin Davidson-Randall</i> |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 21879

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Elsie Deshields</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 28 1996</b>   |  | 3. TIME OF DEATH<br><b>5:35 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>181-20-4792</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>95 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 31, 1901</b>   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Deer's Head Center</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>   |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Wicomico</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>1006 East Road, Apt. 104</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21801</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>House-Wife</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Mc Glotten</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Unknown</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Delrika McGlotten</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1006 East Road, Apt. 104, Salisbury, Md. 21801</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Zion U.M. Church Cemetery 7-5-96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Sharptown, Md.</b>  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John A. Prince</i>  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Bennie Smith Funeral Home<br/>P.O. Box 1687, Easton, Md. 21601</b>  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Cerebro Vascular Accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>Approximate interval Between Onset and Death<br><b>5 weeks</b> |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Primary Degenerative Dementia, Alzheimers type</b><br><b>Seizure Disorder</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M. Shrestha MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D16278</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>6/29/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. M. Shrestha: P. O. Box 2018, Salisbury, Maryland 21802</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 10 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21880

## Certificate of Death

Reg. No.

|   |  |  |   |                                   |  |   |  |  |
|---|--|--|---|-----------------------------------|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Marguerite Louise Dickman  |  |   |                                   | 2. Date of Death<br>Month Day Year<br>July 4 1996  |   | 3. Time of Death<br>830 am   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>141 Newtown Road   |  |   |                                   | 4b. City, Town, or Location of Death<br>Solomons   |   | 4c. County of Death<br>Calvert   |  |
| Funeral<br>Director   | 5. Social Security Number<br>212 24 4763   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F         | 7. Age (In yrs. last birthday)<br>74 Yrs.   | If Under 1 Year<br>Months Days    | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>July 7 1921  |  | 9. Birthplace (State or Foreign Country)<br>Ohio |
|   | Usual Residence of Decedent  |  |   |                                   |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |  | 10b. County<br>Calvert  |                                   | 10c. City, Town or Location<br>Solomons  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br>141 Newton Road  |  |   |                                   | 10f. Zip Code<br>20688   |   | 10g. Citizen of What Country?<br>United States   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>unknown  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>accounting clerk   |                                   | 16b. Kind of Business/Industry<br>PG Government  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Frederick W. Lautsch  |  |   |                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Marie Burmhan  |   |  |  |
| Physician<br>/Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Fred Hall  |  |   |                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 438 Solomons Maryland 20688  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Solomons UMCemetery   |                                   | 20c. Location - City or Town, State<br>Solomons Maryland   |   | 20d. Date<br>July 7, 1996  |  |
|   | 21. Signature of Funeral Service Licensee<br>B. Rausch   |  |   |                                   | 22. Name and Address of Facility<br>Rausch Funeral Home<br>4405 Broomes Is. Rd. Port Republic Md 20676   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Adenocarcinoma of the lung<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                   |  |   |  |  |
|   | Approximate Interval Between Onset and Death<br>6 months   |  |   |                                   |  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|   |  |  |   |                                   |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |  |  |   |                                   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                   |  |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |                                   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28d. Describe how injury occurred |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>Charles W. Bennett M.D.                       |   | 29c. License number<br>D 25156    |  | 29d. Date signed (Month, Day, Year)<br>July 5, 1996 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Charles W. Bennett, MD 11845 HG Trueman Rd. Lusby Maryland 20657  |  |  |   |                                   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL - 5 1996   |  | 32. Registrar's Signature<br>L. Davidson Randall                                       |   |                                   |  |   |  |  |



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State of Maryland / Department of Health and Mental Hygiene

96 21881

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>RICHARD M. DOLIM   |  |   |  | 2. Date of Death<br>Month JULY Day 17, Year 1996   |   |  |  | 3. Time of Death<br>1127 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>ST. AGNES HOSPITAL CHEST PAIN E.R.   |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |   |  |  | 4c. County of Death<br>BALTIMORE   |  |
| Funeral<br>Director   | 5. Social Security Number<br>576-14-5190   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>77 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>MAY 23, 1919                              |  | 9. Birthplace (State or Foreign Country)<br>HAWAII   |  |
|   | Usual Residence of Decedent  |  |   |  |  |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>HAWAII   |  | 10b. County<br>OAHU   |  | 10c. City, Town or Location<br>HONOLULU  |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>6770 HAWAII KAI DRIVE #1402  |  |   |  | 10f. Zip Code<br>96825   |   | 10g. Citizen of What Country?<br>UNITED STATES                                   |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                               |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>FOUNDRY SUPERVISOR  |   |  |  | 16b. Kind of Business/Industry<br>FOUNDRY  |  |
|   | 17. Father's Name (First, Middle, Last)<br>JOSEPH PHILIP DOLIM   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ISABELLA MEDEIROS   |   |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>MICHAEL P. DOLIM   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6421 MANOR VIEW DRIVE, LAYTONSVILLE, MD. 20882  |   |  |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>METROPOLITAN CREMATORY  |  | Date<br>7/19/96  |   | 20c. Location - City or Town, State<br>ALEXANDRIA, VIRGINIA                      |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Marie H. Barber   |  |   |  | 22. Name and Address of Facility<br>MURIEL H. BARBER FUNERAL HOME<br>P.O. BOX 5038 LAYTONSVILLE, MARYLAND 20882  |   |  |  |  |  |
|   | 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Atherosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |   |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Rectal Hemorrhage  |  |   |  |  |   |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |   |  |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |   |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |  |   |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |  |   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>[Signature]  |  |  |   |  | 29c. License number<br>O.C.M.E   |   | 29d. Date signed (Month, Day, Year)<br>JULY 18, 1996                             |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>David R Fowler 111 Penn Street, Baltimore, Maryland 21201   |  |  |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1996  |  |  |   |  | 32. Registrar's Signature<br>John Davidson Randall   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 21882

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Ellis Dunn</b>   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>5</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>6:12 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Doctors Community Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>  |  | 4c. County of Death<br><b>Prince Georges</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>028-28-9764</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 28, 1928</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Oklahoma</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>  |  | 10c. City, Town or Location<br><b>New Carrollton</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>6102 85th Place</b>  |  | 10f. Zip Code<br><b>20784</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>7</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Professor</b>   |  | 16b. Kind of Business/Industry<br><b>University</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Richard Dunn</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bess Lamb</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gretchen E. Dunn</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10</b>   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |
| Physician<br>/Medical<br>Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>  |  | 20c. Date<br><b>7-5-96</b>  |  | 20d. Location - City or Town, State<br><b>Beltsville, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Eileen H. Rapp</b>  |  |
|   | 22. Name and Address of Facility<br><b>Rapp Funeral Services, P. A.<br/>933 Gist Avenue, Silver Spring, MD 20910</b>   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute Myocardial Infarction</b> |  | Approximate Interval Between Onset and Death<br><b>1 hr.</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|   | 29b. Signature and title of certifier<br><b>Michael Bernard, MD</b>  |  | 29c. License number<br><b>D26287</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/5/96</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M. BERARD 7305 Baltimore Ave College Park MD 20740</b>   |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>  |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  | 10   |  | 10  |  |



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State of Maryland / Department of Health and Mental Hygiene

96 21883

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |  |  |
|---|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Sophie Deckelbaum</b>   |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>8</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>3:15 pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Brook Grove Nursing Home</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Olney</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-48-2564</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 10, 1911</b>                                    |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |   |   |  |  |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |   |   |  |  |  |  |  |
|   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Olney</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>18430 Brook Groove Road</b>   |   |   |  | 10f. Zip Code<br><b>20832</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Israel Lubin</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hannah Cohen</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Mench/Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15441 Tinley St. Silver Spring MD 20905</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Lebanon Cemetery</b>   |  | Date<br><b>7/10</b>  |  | 20c. Location - City or Town, State<br><b>Adelphi, MD</b>                                      |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Edward Sagel Funeral Direction</b><br><b>1091 Rockville Pike, Rockville, MD 20852</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>(L) Femoral condylar (Perkera) fracture</b><br>Due to (or as a consequence of):<br>b. <b>Arteriosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Approximate Interval Between Onset and Death<br><b>10 days</b><br><b>20 years</b> |   |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Previous stroke (hypertension)</b>   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day Year)   |   | 28b. Time of injury<br>M                         |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |  | 28d. Describe how injury occurred   |   |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>PO2471</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>July 96</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>   |  | 32. Registrar's Signature<br>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #5, 7/12/96, MRT, Montg. Cty. State of Maryland / Department of Health and Mental Hygiene

96 21884

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |  |  |
|--|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Alice Cecelia Donohoe  |  |   |  | 2. Date of Death<br>Month Day Year<br>July 4, 1996  |  | 3. Time of Death<br>12:35 AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>15308 Basswood Ct.   |  |   |  | 4b. City, Town, or Location of Death<br>Rockville   |  | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director  | 5. Social Security Number<br>577-86-1163<br><del>222-01-6948 A</del>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>87 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Sept. 7, 1908                                 |  |
|  | 9. Birthplace (State or Foreign Country)<br>Wilmington, Del.   |  | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Rockville   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>15308 Basswood Ct.  |  | 10f. Zip Code<br>20853  |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>9 yrs.   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife                                |  | 16b. Kind of Business/Industry<br>own home  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Alphonsus J. Dugan  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary McNespy   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Thomas Donohoe/Son   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>c/o 4201 Butterworth Pl., N.W., Wash., DC 20016  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven  |  | Date<br>Jul. 8, 96  |  | 20c. Location - City or Town, State<br>Silver Spring, Md.                            |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>DeVol Funeral Home<br>2222 Wisconsin Ave., NW<br>Washington, DC 20007   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. End Stage Alzheimers disease<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |   |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |   |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  |  |  | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
|  | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br>D22028   |  | 29d. Date signed (Month, Day, Year)<br>July 5, 1996                                  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Paul Rhodes, M.D. 1902 R St., N.W. Washington, D.C. 20009  |  |   |  |   |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>JUL 09 1996   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

96 21885

Reg. No.

|   |  |  |   |   |  |   |   |   |  |  |
|---|--|--|---|---|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH DRENNEN</b>   |  |   |   |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>7</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>6:55A.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Med Pointe Nursing Home</b>   |  |   |   |  |   | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |   | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-76-2897</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>12/22/1905</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |
|   | Usual Residence of Decedent  |  |   |   |  |   |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Harford</b>   |   | 10c. City, Town or Location<br><b>Havre de Grace</b>   |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>603 Commerce Street</b>   |  |   |   | 10f. Zip Code<br><b>21078</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>4</b>  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |  |   | 16b. Kind of Business/Industry<br><b>Home</b>   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles Goldberg Adams</b>   |  |   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertha Sherman</b>  |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan B. Dorsey Daughter</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>603 Commerce St. Havre de Grace, MD 21078</b>  |   |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Angel Hill Cemetery</b>  |   | Date<br><b>07/10/96</b>  |   | 20c. Location - City or Town, State<br><b>Havre de Grace</b>  |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Madelyn Mitchell Short</b>   |  |   |   |  |   | 22. Name and Address of Facility<br><b>Mitchell-Smith Funeral Home<br/>123 S. Washington St. Havre de Grace, MD</b> |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. coronary artery disease</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |   |   |  |   |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |  |   |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred                                       |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |   |   |   |  |  |
| 29b. Signature and title of certifier<br><b>John Anderson Randall</b>   |  |  |   | 29c. License number<br><b>028339</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 7, 1996</b>  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>LINDA FUELLICH 101 E Wheel Road Bel Air MD 21015</b>   |  |  |   |   |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 9 1996</b>  |  | 32. Registrar's Signature<br><b>John Anderson Randall</b>                              |   |   |  |   |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELEANOR C DENNISON</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>JULY</b> DAY <b>11</b> YEAR <b>1996</b>  |  | 3. TIME OF DEATH<br><b>03:40 a.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-38-8678</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 12, 1912</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. MARY'S HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LEONARDTOWN</b>  |  |
| 9c. COUNTY OF DEATH<br><b>ST. MARY'S</b>   |  |   |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>ST. MARY'S</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>MECHANICSVILLE</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>29787 KING RD.</b>  |  |
| 10f. ZIP CODE<br><b>20659</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ROBERT L. COLLINS</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARTHA TILCH</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARTHA M. EMOND/DAUGHTER</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>149 BALLANTRAE DR. ELKTON, MARYLAND 21921</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. JOHN'S CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>7/15 FT. WASHINGTON, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>BENJAMIN M. MATTHEWS</i><br><b>BENJAMIN M. MATTHEWS M-00658</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156 WALDORF, MARYLAND 20604</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CONGESTIVE HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>CAD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William Boyd</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D14285</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7-11-96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WILLIAM BOYD, Leonardtown, MD</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 15 1996</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |                              |
|---|---|--|--|--|---|--|------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Ralph Gray Davis Jr.  |  |  |  | 2. Date of Death<br>Month Day Year<br>July 7 1996   |  | 3. Time of Death<br>2213     |
|   | 4a. Facility Name (If not institution, give street and number)<br>Union Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Elkton Md.  |  | 4c. County of Death<br>Cecil |
| Funeral<br>Director   | 5. Social Security Number<br>219-16-4316  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>72 Yrs.  | 8. Date of Birth (Month, Day, Year)<br>July 19, 1923 | 9. Birthplace (State or Foreign Country)<br>Maryland  |  |                              |
|   | Usual Residence of Decedent   |  |  |  |   |  |                              |
| To Be Completed by Funeral Director   | 10a. State<br>Md.   | 10b. County<br>Cecil   | 10c. City, Town or Location<br>Elkton  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |                              |
|   | 10e. Street and Number<br>245 E. Main Street  |  |  | 10f. Zip Code<br>21921                               | 10g. Citizen of What Country?<br>U.S.A.   |  |                              |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                              |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12+   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Proprietor                                |  | 16b. Kind of Business/Industry<br>Floral  |  |                              |
|   | 17. Father's Name (First, Middle, Last)<br>Ralph Gray Davis Sr.   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margery Marshbank Davis   |  |   |  |                              |
| To Be Completed by Physician/Medical Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br>Margery Davis Maize Sister  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7409 Georgetown Pike, McLean Virginia 22102           |  |   |  |                              |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>R.A. Ferris Inc.   |  | 20c. Location - City or Town, State<br>July 9, 96 West Chester Pa.  |  |                              |
|   | 21. Signature of Funeral Service Licensee<br>Edward McKeown   |  | 22. Name and Address of Facility<br>Gee Funeral Home 259 E. Main St. Elkton,   |  |   |  |                              |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                              |  |  |  |   |  |                              |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                              |  |  |  |   |  |                              |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |  |   |  |                              |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |   |  |                              |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |  |   |  |                              |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |  |  |   |  |                              |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  |  |  |   |  |                              |
| 28a. Date of injury (Month, Day Year)<br>28b. Time of injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |   |  |                              |
| 28d. Describe how injury occurred   |   |  |  |  |   |  |                              |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |   |  |                              |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |   |  |                              |
| 29b. Signature and title of certifier<br>Joseph M. High M.D.  |   |  |  |  |   |  |                              |
| 29c. License number<br>044716   |   |  |  |  |   |  |                              |
| 29d. Date signed (Month, Day, Year)<br>7/8/96   |   |  |  |  |   |  |                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph M. High III W. High St, Elkton Md.   |   |  |  |  |   |  |                              |
| 31. Date filed (Month, Day, Year)<br>7/8/96   |   |  |  |  |   |  |                              |
| 32. Registrar's Signature<br>Julia Davidson-Randall   |   |  |  |  |   |  |                              |

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atomic nucleus.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atomic nucleus.

3. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atomic nucleus.

4. The fourth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atomic nucleus.

5. The fifth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atomic nucleus.

6. The sixth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atomic nucleus.

7. The seventh part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atomic nucleus.

8. The eighth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atomic nucleus.

9. The ninth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atomic nucleus.

96 21888

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Wanda Mae Denton</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 7, 1996</b>   |  | 3. TIME OF DEATH<br><b>8:31 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-38-9171</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>67 YRS.</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 3, 1929</b>                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>West VA.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Naval Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Patuxent River</b>                                    |  |
| 9c. COUNTY OF DEATH<br><b>St. Mary's</b>  |  |  |  | 10. RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>St. Mary's</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Great Mills</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>430 Greenview Village</b>  |  |  |  | 10f. ZIP CODE<br><b>20634</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Employee Development Specialist U.S. Government</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Oliver Otis H. O'Dell</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maude E. Samples</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>James E. Denton</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1123 Salisbury Dr. Midlothian, VA 23113</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Evergreen Memorial 7/10/96 California, MD</b>  |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael H. Gardiner</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Probable Myocardial Infarction sec</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William D. Boyd, II, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>824285</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/8/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William D. Boyd, II, M.D. Leonardtown, Maryland 20650</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL - 9 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21889

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ILENE ELVA ECKER

2. Date of Death

July 10, 1996

3. Time of Death

4:25 PM

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

219-07-4135

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 5, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2105 Woodview Rd.

10f. Zip Code

Finksburg

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing Factory

17. Father's Name (First, Middle, Last)

Leonard Smith

18. Mother's Name (First, Middle, Maiden Surname)

E. Gay Hylton

19a. Informant's Name/Relationship (Type, Print)

Virginia Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2105 Woodview Rd. Finksburg, Md. 21048

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pipe Creek Cemetery

Date

7/13/96

20c. Location - City or Town, State

Linwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

D.D. Hartzler  
New Windsor, Md. 21776

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. NON SMALL CELL LUNG CARCINOMA

1 MONTH

Due to (or as a consequence of):

b. WITH LIVER METASTASIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dan H. Schaefer, MD

29c. License number

D28221

29d. Date signed (Month, Day, Year)

JULY 10, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAN H. SCHAEFER, MD 200 MEMORIAL AVENUE WESTMINSTER MARYLAND

31. Date filed (Month, Day, Year)

JUL 15 1996

32. Registrar's Signature

John A. Anderson

21157

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21890

## Certificate of Death

Reg. No.

|   |   |   |  |   |   |   |   |  |  |  |  |
|---|---|---|--|---|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Helena A. Ehleben</b>                          |   |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>6</b> Year <b>1996</b> |   | 3. Time of Death<br><b>2:30 AM</b>                              |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>8144 Hartford Avenue</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>        |   | 4c. County of Death<br><b>Montgomery</b>                        |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>None</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  | If Under 1 Year<br>Months Days                                      | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>March 28, 1903</b> | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>   |  |  |  |
|   | Usual Residence of Decedent   |   |  |   |   |   |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>   |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br><b>8144 Hartford Avenue</b>   |   |   |  | 10f. Zip Code<br><b>20910</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>                                       |   |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>  |   |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Friedrich Romer</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Grossman</b>   |   |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michele Vobe</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10</b>  |   |   |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>   |  | Date<br><b>7-6-96</b>   |   | 20c. Location - City or Town, State<br><b>Beltsville, Maryland</b>                          |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Deleen H. Rapp</b>  |   |   |  | 22. Name and Address of Facility<br><b>Rapp Funeral Services, P. A.<br/>933 Gist Avenue, Silver Spring, MD 20910</b>  |   |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><br>b. <b>Ischemic Heart Disease</b><br>Due to (or as a consequence of):<br><br>c. <b>Alzheimer's Disease</b><br>Due to (or as a consequence of):<br><br>d. <b>Generalized Arteriosclerosis</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Approximate Interval Between Onset and Death<br><br>1 month<br>4 years<br>4 years<br>10 years |   |   |  |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Starvation</b>   |   |   |  |   |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><b>Roland Imperial MD</b>  |  |   |   | 29c. License number<br><b>DD 5276</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>July 6, 1996</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Roland Imperial, M. D., 4977 Battery Lane, #106, Bethesda, MD 20814</b>  |   |   |  |   |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>   |   |   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |   |   |   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21891

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |   |  |  |
|---|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>RUTH L. EVANS   |  |   |  | 2. Date of Death<br>Month Day Year<br>JULY 13 1996 |   | 3. Time of Death<br>8:29 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>ANNAPOLIS NURSING & REHAB. CENTER |  |   |  | 4b. City, Town, or Location of Death<br>ANNAPOLIS  |   | 4c. County of Death<br>ANNE ARUNDEL  |  |
| Funeral<br>Director   | 5. Social Security Number<br>577-52-8674  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>89 Yrs.          |   | 8. Date of Birth (Month, Day, Year)<br>FEB. 14 1907                                  |  |
|   | 9. Birthplace (State or Foreign Country)<br>OHIO  |  | 10a. State<br>MARYLAND  |  | 10b. County<br>ANNE ARUNDEL                        |   | 10c. City, Town or Location<br>ANNAPOLIS   |  |
| Usual Residence of Decedent   |   |  |   |  |  |   |  |  |
| 10a. State<br>MARYLAND  |   |  | 10b. County<br>ANNE ARUNDEL   |  |  | 10c. City, Town or Location<br>ANNAPOLIS  |  |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  | 10e. Street and Number<br>1012 BOUCHERR AVENUE  |  |  | 10f. Zip Code<br>21403  |  |  |
| 10g. Citizen of What Country?<br>US   |   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                                    |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER  |   |  | 16b. Kind of Business/Industry<br>OWN HOME  |  |  | 17. Father's Name (First, Middle, Last)<br>EDWIN L. JACOBY  |  |  |
| 18. Mother's Name (First, Middle, Maiden Summa)<br>MABEL J. LUELLEN   |   |  | 19a. Informant's Name/Relationship (Type, Print)<br>PATRICIA KREUTZER (DAUGHTER)  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1012 BOUCHER AVE. ANNAPOLIS, MD. 21403               |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>METRO CREMATORY   |  |  | 20c. Location - City or Town, State<br>7/14/96 BALTIMORE, MD.   |  |  |
| 21. Signature of Funeral Service Licensee<br>Harry D. Reese   |   |  | 22. Name and Address of Facility<br>WM. REESE & SONS MORTUARY, P.A.<br>821 WEST ST. ANNAPOLIS, MD. 21401  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Renal Failure<br>Due to (or as a consequence of):<br>b. Diabetes Mellitus<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |  |   |  |  |   |  | Approximate Interval Between Onset and Death<br>3 months<br>25 years   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M                           |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred   |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br>R.I. Hochman, M.D.   |   |  | 29c. License number<br>D05192   |  |  | 29d. Date signed (Month, Day, Year)<br>7/13/96  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>R.I. Hochman, M.D., 1833A Forest Drive, Annapolis, Md. 21401  |   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 15 1996  |   |  | 32. Registrar's Signature<br>Julia Davidson-Randall   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21892

## Certificate of Death

Reg. No.

|   |  |   |   |   |   |  |  |   |
|---|--|---|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MILTON JOSEPH FALK</b>                      |   |   |   | 2. Date of Death<br>Month <b>July</b> Day <b>5</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>6:00 A.M.</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>329 Gorman Avenue</b> |   |   |   | 4b. City, Town, or Location of Death<br><b>Laurel,</b>  |  | 4c. County of Death<br><b>Prince Georges</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>066-20-0206</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>April 24, 1927</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |
|   | Usual Residence of Decedent  |   |   |   |   |  |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Silver Spring</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>3151 Adderley Court</b>  |  |   |   | 10f. Zip Code<br><b>20707</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b>5+</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Statistician</b>  |   |  | 16b. Kind of Business/Industry<br><b>U.S. Dep't of Labor Federal Government</b>                |   |
| 17. Father's Name (First, Middle, Last)<br><b>George Falk</b>   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Krieger</b>   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Emily M. Moser - Daughter</b>  |  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>329 Gorman Avenue, Laurel, Maryland 20707</b> |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Crematory</b> |   | Data<br><b>7-6-96</b>   |  | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>                              |   |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   |   | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home, Inc.<br/>11800 New Hampshire Avenue, Silver Spring, MD 20904</b>               |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>3 mo</b> |  |   |   |   |   |  |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |  |   |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D 21611</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/5/96</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John Barr, MD 10810 Conn Ave, Kensington, Md 20895</b>   |  |   |   |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>   |  |   |   | 32. Registrar's Signature<br>   |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

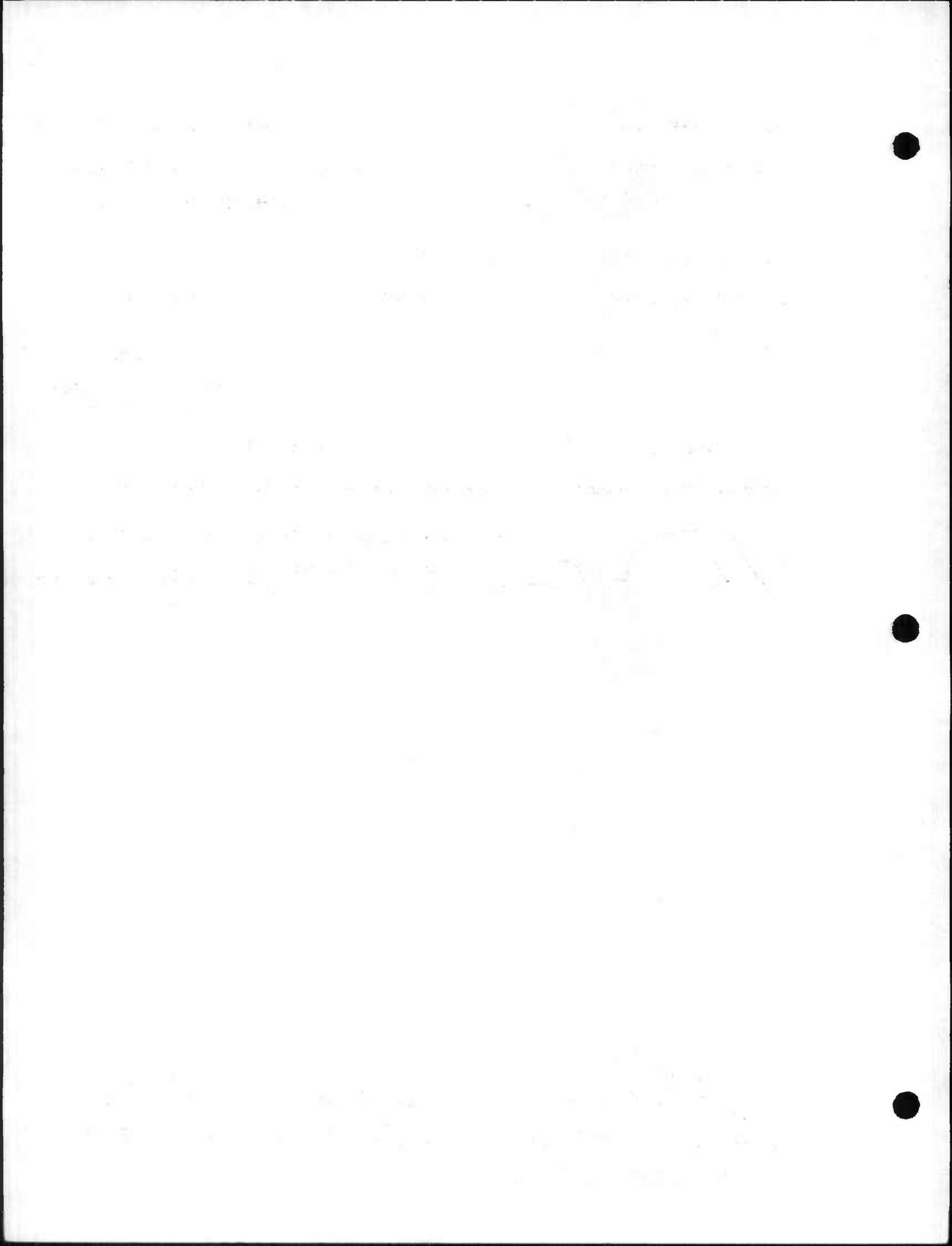
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10


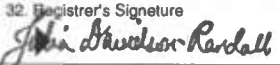
State  
Registrar



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 21893

Reg. No.

|   |   |  |   |  |   |  |  |  |  |   |  |  |  |   |  |
|---|---|--|---|--|---|--|--|--|--|---|--|--|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>LILLIAN MIRIAM FOLKERS</b>   |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 10, 1996</b>   |  | 3. Time of Death<br><b>04:32 PM</b>  |   |  |  |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MALCOLM GROW MEDICAL CENTER</b>  |  |   |  |   |  | 4b. City, Town, or Location of Death<br><b>CAMP SPRINGS</b>  |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |   |  |  |  |   |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>220-28-6183</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 19, 1921</b>   |  | 9. Birthplace (State or Foreign Country)   |   |  |  |  |   |  |
|   | Usual Residence of Decedent   |  |   |  |   |  |  |  |  |   |  |  |  |   |  |
| <b>To Be Completed by Funeral Director</b>  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Charles</b>   |  | 10c. City, Town or Location<br><b>Indian Head</b>   |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |  |  |   |  |
|   | 10e. Street and Number<br><b>Rt. 2, Box 62A</b>   |  |   |  | 10f. Zip Code<br><b>20640</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |   |  |  |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |   |  |  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  | 16b. Kind of Business/Industry<br><b>Her Home</b>                                    |  |   |  |  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Oliver George Buck</b>  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Marie Warner</b>  |  |  |   |  |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kenneth Allen Folkers Son</b>  |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9522 Tudor Oaks Drive, Manassas, Va. 20110</b> |  |  |   |  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Rest</b>   |  | 20c. Location - City or Town, State<br><b>July 14, 1996</b><br><b>LaPlata, Maryland</b>  |  |  |   |  |  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br> <b>M00668</b>   |  |   |  | 22. Name and Address of Facility<br><b>Williams Funeral Home, P.A.<br/>Indian Head, Maryland</b>  |  |  |  |  |   |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>RESPIRATORY ARREST</b><br>Due to (or as a consequence of):<br>b. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE EXACERBATION</b><br>Due to (or as a consequence of):<br>c. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>MINUTES</b>   |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NON Q WAVE MYOCARDIAL INFARCTION</b>   |  |   |  |   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |  |  |  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>4301406999</b>     |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 10, 1996</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES W. ORTMEYER, MAJ, USAF, MC</b>   |   |  |   |  |   |  |  |  |  | <b>89 MDG / 1050 W PERIMETER RD SUITE C1-7</b>  |  | <b>ANDREWS AIR FORCE BASE, MD 20762-6600</b> |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>   |   |  |   | 32. Registrar's Signature<br> |   |  |  |  |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.


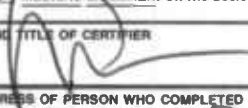
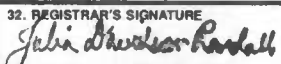




96 21894

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Marie M. Foglesong</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>07</b> DAY <b>07</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>3:30 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-46-2638</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 18, 1910</b>                                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1100 Old Westminster Pike</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>   |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Carroll</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Westminster</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1100 Old Westminster Pike</b>  |  |  |  | 10f. ZIP CODE<br><b>21157</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Housework</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Cleveland Barnhart</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Della Bechtel</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy Munshaur</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1100 Old Westminster Pike Westminster, MD 21157</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Mary's Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Silver Run, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>34 Maple Ave. Littlestown, PA 17340</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Colon cancer</b><br>Approximate interval between Onset and Death <b>months</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Heart Failure</b>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D33165</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/8/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Steven Shaffer 2111 Hanover Pike Hanover 2 md 21074</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 10 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21895

## Certificate of Death

Reg. No.

|   |   |   |   |                                      |  |  |   |  |   |                         |  |                                   |            |
|---|---|---|---|--------------------------------------|--|--|---|--|---|-------------------------|--|-----------------------------------|------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES ELLSWORTH FORREST</b>  |   |   |                                      | 2. Date of Death<br>Month <b>JULY</b> Day <b>9</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>6:50 PM</b>                                      |  |   |                         |  |                                   |            |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ST. MARTIN NECK ROAD</b>   |   |   |                                      | 4b. City, Town, or Location of Death<br><b>BISHOPVILLE</b>   |  | 4c. County of Death<br><b>WORCESTER</b>                                 |  |   |                         |  |                                   |            |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-14-2775</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>APR. 10, 1913</b>             |  |   |                         |  |                                   |            |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |   | 10a. State<br><b>MD</b>   |                                      | 10b. County<br><b>TALBOT</b>   |  | 10c. City, Town or Location<br><b>OXFORD</b>                            |  |   |                         |  |                                   |            |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |                                      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |                         |  |                                   |            |
|   | 10e. Street and Number<br><b>404 MAIN ST.</b>   |   |   |                                      | 10f. Zip Code<br><b>21654</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |   |                         |  |                                   |            |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |                         |  |                                   |            |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>WATERMAN</b>                      |                                      | 16b. Kind of Business/Industry<br><b>SEAFOOD INDUSTRY</b>  |  |   |  |   |                         |  |                                   |            |
|   | 17. Father's Name (First, Middle, Last)<br><b>ERNEST BENJAMIN FORREST</b>   |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELLEN PASQUITH</b>   |  |   |  |   |                         |  |                                   |            |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>CHARLES S. FORREST/SON</b>   |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>504 32ND ST. #2, OCEAN CITY, MD 21842</b>  |  |   |  |   |                         |  |                                   |            |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OXFORD CEMETERY</b>  |                                      | Date<br><b>7-13</b>  |  | 20c. Location - City or Town, State<br><b>OXFORD, MD</b>                |  |   |                         |  |                                   |            |
|   | 21. Signature of Funeral Service Licensee<br><b>B. Keith Phyllis, CFSP</b>  |   |   |                                      | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD</b>   |  |   |  |   |                         |  |                                   |            |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |                                      |  |  |   |  |   |                         |  |                                   |            |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>HEART FAILURE</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>2 YEARS</b></td> </tr> <tr> <td>b. <b>FAMILIAL CARDIOMYOPATHY</b></td> </tr> <tr> <td>c. <b></b></td> </tr> <tr> <td>d. <b></b></td> </tr> </table> |   |   |                                      |  |  |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>HEART FAILURE</b> | Approximate Interval Between Onset and Death<br><b>2 YEARS</b> | b. <b>FAMILIAL CARDIOMYOPATHY</b> | c. <b></b> |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>HEART FAILURE</b>   | Approximate Interval Between Onset and Death<br><b>2 YEARS</b>  |   |                                      |  |  |   |  |   |                         |  |                                   |            |
|   | b. <b>FAMILIAL CARDIOMYOPATHY</b>   |   |   |                                      |  |  |   |  |   |                         |  |                                   |            |
|   | c. <b></b>  |   |   |                                      |  |  |   |  |   |                         |  |                                   |            |
|   | d. <b></b>  |   |   |                                      |  |  |   |  |   |                         |  |                                   |            |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |                                      |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |                         |  |                                   |            |
|   |   |   |   |                                      |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                         |  |                                   |            |
|   |   |   |   |                                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |                         |  |                                   |            |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                      |  |  |   |  |   |                         |  |                                   |            |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |                         |  |                                   |            |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred    |  |  |   |  |   |                         |  |                                   |            |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>C. W. Bain MD</b>   |   | 29c. License number<br><b>D00250</b> |  | 29d. Date signed (Month, Day, Year)<br><b>7/11/96</b>  |   |  |   |                         |  |                                   |            |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>C.R.W. BAIN, M.D., 415 E. DOVER ST., EASTON, MD 21601</b>  |   |   |   |                                      |  |  |   |  |   |                         |  |                                   |            |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 1996</b>   |   | 32. Registrar's Signature<br><b>Julia Davidson-Rendall</b>  |   |                                      |  |  |   |  |   |                         |  |                                   |            |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is devoted to a general survey of the situation in the country.

It is found that the country is in a state of general depression.

The main cause of this is the lack of capital and the consequent stagnation of industry.

The government has tried to remedy this by various measures, but without success.

The only way to overcome this is by a complete reorganization of the economy.

This is the only way to bring about a revival of the country.

2. The second part of the report deals with the question of the land.

It is found that the land is in a state of general neglect.

The main cause of this is the lack of capital and the consequent stagnation of industry.

The government has tried to remedy this by various measures, but without success.

The only way to overcome this is by a complete reorganization of the economy.

This is the only way to bring about a revival of the country.

3. The third part of the report deals with the question of the labor.

It is found that the labor is in a state of general depression.

The main cause of this is the lack of capital and the consequent stagnation of industry.

The government has tried to remedy this by various measures, but without success.

The only way to overcome this is by a complete reorganization of the economy.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21896

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |   |  |
|---|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Luther Craton Foster</b>                              |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>6</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>9:27 AM</b>   |   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Memorial Hospital at Easton</b> |   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>  |  | 4c. County of Death<br><b>Talbot</b>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-16-6957</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>72 Yrs.</b> |  | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 17, 1924</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |  |  |  |  |   |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Dorchester</b>  |  | 10c. City, Town or Location<br><b>Preston</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>21556 Marsh Creek Road</b>   |  |   |  | 10f. Zip Code<br><b>21655</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Gardener</b>   |  | 16b. Kind of Business/Industry<br><b>Lawn Engineer</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles F. Foster</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Lillie Mae Friend</b>  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Alice F. Myers</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10805 N. Keys Road, Brandywine, Md. 20613</b>  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Pleasant Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>7/13/96 Preston, Md.</b>   |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Bennie Smith Funeral Home<br/>P.O. Box 1687, Easton, Maryland 21601</b>   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div> <p>a. <b>acute myocardial infarction</b><br/>Due to (or as a consequence of):</p> <p>b. <b>coronary artery disease</b><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____<br/>Due to (or as a consequence of):</p> </div> <div> <p>Approximate Interval Between Onset and Death<br/><b>minutes</b></p> </div> </div> |  |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>renal failure</b>  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how Injury occurred  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D47534</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/6/96</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wafik I. Zaki, M.D., Shore Clinical Foundation, 920 Market St, Denton, Md. 21629</b>   |  |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>   |  | 32. Registrar's Signature<br>   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21897

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ALBERT FRANKEL                         |   |  |  | 2. Date of Death<br>Month Day Year<br>JULY 10 1996 |   | 3. Time of Death<br>1:10 AM                          |   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br>MANOR CARE LARGO |   |  |  | 4b. City, Town, or Location of Death<br>LARGO      |   | 4c. County of Death<br>PRINCE GEORGE'S               |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>010-16-8961   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>87 Yrs.          |   | 8. Date of Birth (Month, Day, Year)<br>APR. 15, 1909 |   |  |
|  | 9. Birthplace (State or Foreign Country)<br>MASSACHUSETTS                          |   | 10a. State<br>MARYLAND   |  | 10b. County<br>PRINCE GEORGES                      |   | 10c. City, Town or Location<br>LAUREL                |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br>9000 BRIARCROFT LANE   |  | 10f. Zip Code<br>20708  |  | 10g. Citizen of What Country?<br>UNITED STATES  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SALESMAN   |  | 16b. Kind of Business/Industry<br>FURNITURE  |  | 17. Father's Name (First, Middle, Last)<br>MORRIS FRANKEL   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ROSE ALTMAN  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>MARTIN FRANKEL (SON)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3803 IDLE COURT - BOWIE, MARYLAND 20715  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SHARON MEMORIAL PARK            |  | 20c. Location - City or Town, State<br>7/11/96 SHARON, MASSACHUSETTS  |  |
| 21. Signature of Funeral Service Licensee<br><i>Kathleen Broenne</i>   |  | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS<br>1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>End Stage Renal Disease</i><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death<br><i>Several years</i>                                      |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                              |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Rakesh Arora, MD</i>  |  | 29c. License number<br>D20108  |  | 29d. Date signed (Month, Day, Year)<br>7/10/96  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>RAKESH ARORA, MD - 14300 GALLANT FOX LANE, BOWIE, MARYLAND 20715   |  | 31. Date filed (Month, Day, Year)<br>JUL 12 1996  |  | 32. Registrar's Signature<br><i>Johanna Davidson-Rendell</i>   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21898

## Certificate of Death

Reg. No.

|  |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>TERENCE FITZPATRICK</b>                             |  |  |   | 2. Date of Death<br>Month Day Year<br><b>JULY 07 1996</b>   |  | 3. Time of Death<br><b>3:30 am</b>   |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Northwest Hospital Center</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Randallstown</b> |  | 4c. County of Death<br><b>Baltimore</b>  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-44-4610</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 9, 1944</b>                                     |  |  |
|  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Carroll</b>  |   | 10c. City, Town or Location<br><b>Sykesville</b>            |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Unknown</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>  |   | 16b. Kind of Business/Industry<br><b>Maintenance/Private</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Bernard J. Fitzpatrick</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Mitchell</b>   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ruth M. Fitzpatrick</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15107 Interlachen Drive #707 Silver Spring, Maryland 20906</b>  |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>7/9/96 Silver Spring, Maryland</b>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W. Sil. Spr., MD 20901</b>   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>LIVER CIRRHOSIS</b><br>Due to (or as a consequence of):<br><b>HEPATITIS C</b><br>Due to (or as a consequence of):<br><b>ACUTE RENAL FAILURE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |   |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |  |  |  |  |
|  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  |  |  |  | 28d. Describe how injury occurred   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  | 29b. Signature and title of certifier<br>   |   |  |  | 29c. License number<br><b>D45045</b>   |  |
|  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 07 1996</b>  |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ACBOCU N. NORTHWEST HOSP CENTER, BALTO, MD</b>  |  |  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>  |  |  |  | 32. Registrar's Signature<br>   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 21899

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |  |  |   |
|---|--|---|---|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BERNARD FRIEDMAN</b>  |   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 8, 1996</b>                    |  | 3. Time of Death<br><b>9:30 PM</b>                   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HEBREW HOME OF GREATER WASHINGTON</b> |   |   |   |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>                     |  | 4c. County of Death<br><b>MONTGOMERY</b>             |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>070-14-6570</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 28, 1904</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>POLAND</b>   |
|   | Usual Residence of Decedent  |   |   |   |  |  |  |  |   |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>MONTGOMERY</b>  |   | 10c. City, Town or Location<br><b>ROCKVILLE</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 10a. Street and Number<br><b>6105 MONTROSE ROAD</b>   |  |   |   |   | 10f. Zip Code<br><b>20852</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SHIPPING CLERK</b>  |  |  | 16b. Kind of Business/Industry<br><b>RECORD</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>SHLOMO FRIEDMAN</b>   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DOBE (UNAVAILABLE)</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARCIA GOODMAN (NIECE)</b>   |  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>801 WHITTINGTON TERRACE - SILVER SPRING, MD. 20901</b> |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HAR HAMNUCHOT</b>  |   | Date<br><b>7/10/96</b>   |  | 20c. Location - City or Town, State<br><b>JERUSALEM, ISRAEL</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |   |   | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852</b>                   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Dehydration</b><br>Due to (or as a consequence of):<br>b. <b>Dysphagia</b><br>Due to (or as a consequence of):<br>c. <b>Alzheimer's dementia</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>4 days</b><br><b>4 days</b><br><b>years</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arteriosclerotic heart disease</b>   |  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |  |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
|   |  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   | 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |   |  | 29c. License number<br><b>D23958</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/7/96</b> |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Burt I. Feldman M.D., 6105 Montrose Rd., Rockville MD 20852</b>  |  |   |   |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>   |  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 21900

## Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last)

ANGIE

LYNN

FRENCH

2. Date of Death

Month

Day

Year

JULY

06

1996

3. Time of Death

1103 AM

Physician  
/Medical  
Examiner

4a. Facility Name (If not institution, give street and number)

UNIVERSITY HOSPITAL S.T.U

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

219-94-6079

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

31

8. Date of Birth

If Under 1 Year

Months Days

9. Birthplace (State or Foreign Country)

July 21, 1964

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

305 Barrows Ct.

10f. Zip Code

21078

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Harford Co. Schools

17. Father's Name (First, Middle, Last)

David Phillip Newman

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Lucille Fancher

19a. Informant's Name/Relationship (Type, Print)

David A. French Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

305 Barrows Ct. Havre de Grace, Md. 21078

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Chapel U.M. Cem.

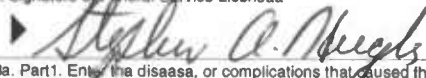
Date

7-10-96

20c. Location - City or Town, State

Joppa, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Howard K. McComas III  
Funeral Home, P.A.  
1317 Cokesbury Rd.  
Abingdon, Md. 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Contact Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

PARTIAL

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☒ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

7-5-96

28b. Time of Injury

1545 M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Self Inflicted

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

305 Barrows Court

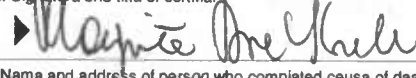
Harford County, MD

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 8, 1996

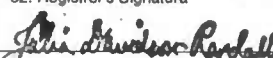
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MSD/SMITH P-KORSHAK 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 10 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

96 21901

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |  |  |  |
|--|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>MILTON ROSS FITCH   |  |   |   | 2. Date of Death<br>Month Day Year<br>July 9, 1996   |  | 3. Time of Death<br>4:25 PM                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Carroll County General Hospital   |  |   |   | 4b. City, Town, or Location of Death<br>Westminster  |  | 4c. County of Death<br>Carroll                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-36-4346  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>77 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>Sept. 9, 1918  | 9. Birthplace (State or Foreign Country)<br>Maryland             |  |
|  | Usual Residence of Decedent   |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  | 10b. County<br>Carroll   | 10c. City, Town or Location<br>Westminster  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>1217 Random Ridge Road  |  |   |   | 10f. Zip Code<br>21157   |  | 10g. Citizen of What Country?<br>United States                   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+)  |  |   | 16e. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Farmer  |  | 16b. Kind of Business/Industry<br>Agriculture  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Ross Washington Fitch  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Freida Sophia Babikow   |  |  |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br>Elaine M. Fitch   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1217 Random Ridge Road, Westminster, MD 21157   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Carroll Cremation Services  |   | Date<br>7/10   |  | 20c. Location - City or Town, State<br>Hampstead, Maryland       |  |
|  | 21. Signature of Funeral Service Licensee<br>Robert A. Myers  |  |   |   | 22. Name and Address of Facility<br>Myers Funeral Home<br>91 Willis Street, Westminster, MD 21157  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |  |   |   |  |  |  |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br>e. Acute Cerebral Vascular accident<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.        |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)                                      |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   | 28d. Describe how injury occurred   |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>M. Nasir MD   |   |  |   | 29c. License number<br>D35711   |  | 29d. Date signed (Month, Day, Year)<br>7/10/96   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Dr. Mokhtar Nasir 295 Stoner Road, Westminster, MD 21157   |   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 10 1996   |   |  |   |   |  |  |  |  |
| 32. Registrar's Signature<br>John Andrew Randall   |   |  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 21902

## Certificate of Death

Reg. No.

|  |   |  |  |   |   |  |   |  |
|--|---|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner                          | 1. Decedent's Name (First, Middle, Last)<br><b>ROSEL GOLDMAN</b>  |  |  |   | 2. Date of Death<br>Month <b>JULY</b> , Day <b>2</b> , Year <b>1996</b>   |  | 3. Time of Death<br><b>2:15 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-42-4747</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>AUGUST 30, 1935</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b>   |  | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>POTOMAC</b>   |  |
| To Be Completed by Funeral Director                        | Usual Residence of Decedent   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>8108 APPALACHIAN TERRACE</b>   |  | 10f. Zip Code<br><b>20854</b>   |  |
|  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BOOKKEEPER</b>  |  | 16b. Kind of Business/Industry<br><b>HARDWARE STORE</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>MORRIS LOUIS DENIS</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SHIRLEY TURKISH</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>ALAN GOLDMAN (HUSBAND)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8108 APPALACHIAN TERRACE - POTOMAC, MARYLAND 20854</b>  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JUDEAN MEMORIAL GARDENS</b>   |   | 20c. Date<br><b>7/3/96</b>  |  | 20d. Location - City or Town, State<br><b>OLNEY, MARYLAND</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852</b>  |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC NON-SMALL CELL LUNG CANCER</b><br>Due to (or as a consequence of):<br><br><b>b. </b><br>Due to (or as a consequence of):<br><br><b>c. </b><br>Due to (or as a consequence of):<br><br><b>d. </b> |  | Approximate Interval Between Onset and Death<br><b>1 YEAR</b>   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  |
|  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D33293</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>JULY 2, 1996</b> |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FREDERICK SMITH, MD - 5401 WISCONSIN AVENUE NW - WASHINGTON, D.C. 20015</b> |  | 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b> |   | 32. Registrar's Signature<br> |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

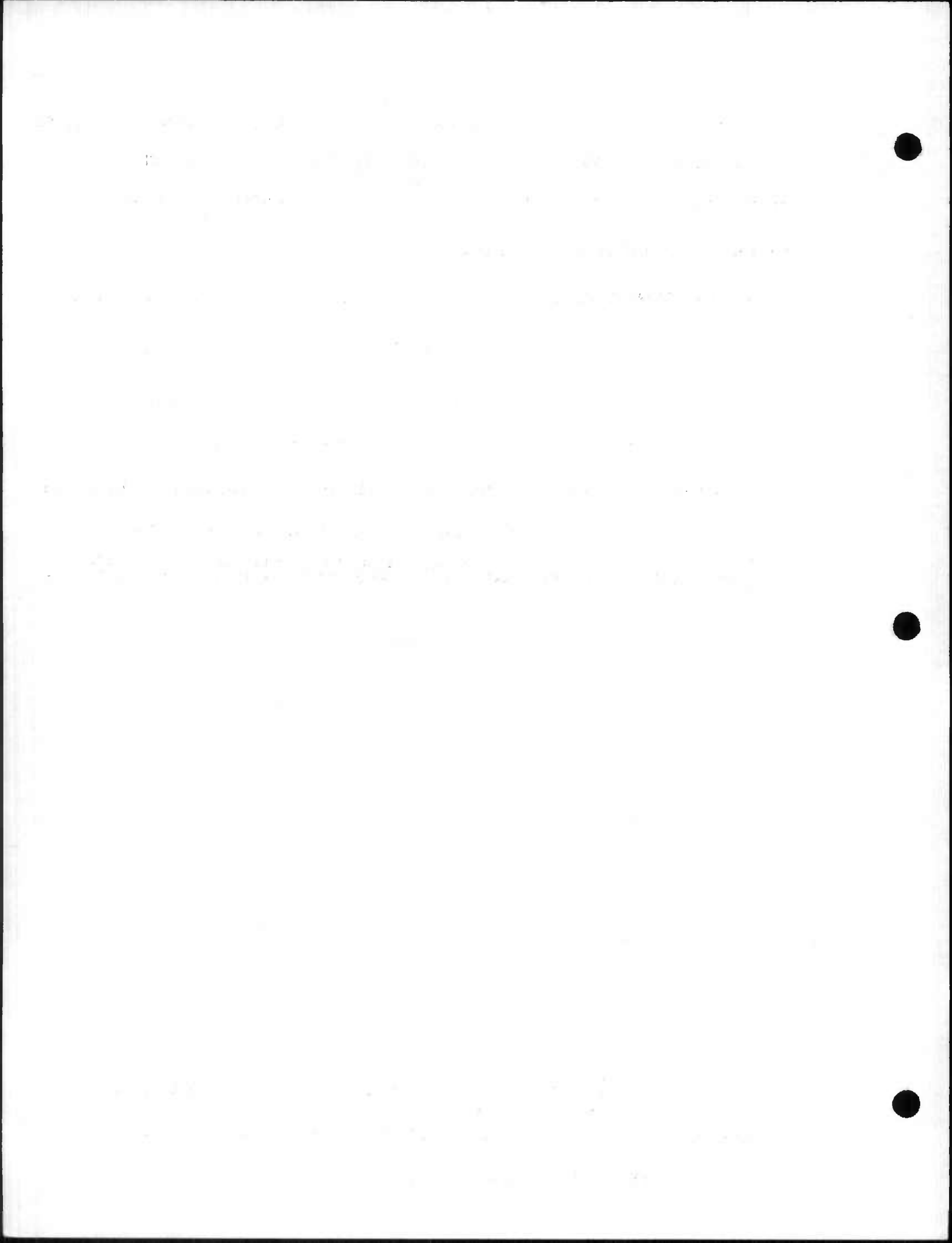
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 21903

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ERMA G. GUERIN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>07-08-96</b>   |  | 3. TIME OF DEATH<br><b>6:50 P.M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>578-50-3340</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 27, 1908</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carriage Hill of Silver Spring</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                  |   |
| 10e. STREET AND NUMBER<br><b>2201 Colston Drive, Apt. 509 A</b>   |  |  |  | 10f. ZIP CODE<br><b>20910</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1942-1945</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Office Manager</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Federal Government</b>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Fred Green</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Melanie Schmitt</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edith Green Gatlin</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9722 Hedin Drive, Silver Spring, Maryland 20903</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery 7/18/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Arlington, VA</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis J. Collins Funeral Home, Inc. 20901<br/>500 University Blvd. W. Silver Spring, MD</b> |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles J. Cole</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis J. Collins Funeral Home, Inc. 20901<br/>500 University Blvd. W. Silver Spring, MD</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral Atherosclerosis.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Davidson-Randall MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 27865</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/8/1996</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARK K. LE MD 1721 University Blvd W, Wheaton MD 20902</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 11 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2020-2021 - 2021-2022

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21904

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>HERMAN GLAZER</b>  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>11</b> , Year <b>1996</b>  |   | 3. Time of Death<br><b>1:35 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>  |  |   | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |
| 5. Social Security Number<br><b>093-14-0115</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>MAY 14, 1924</b>   |
| 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b>   |  |   |   |  |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>MONTGOMERY</b>  |   | 10c. City, Town or Location<br><b>BETHESDA</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |
| 10e. Street and Number<br><b>5225 POOKS HILL ROAD #1812S</b>  |  |   | 10f. Zip Code<br><b>20814</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CERTIFIED PUBLIC ACCOUNTANT</b>   |   | 16b. Kind of Business/Industry<br><b>ACCOUNTING</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>BENJAMIN GLAZER</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LENA GOLDEN</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DANIEL GLAZER (SON)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>29 HOLLYBERRY COURT - ROCKVILLE, MARYLAND 20852</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING DAVID MEMORIAL GDN.</b>   |   | 20c. Location - City or Town, State<br><b>FALLS CHURCH, VIRGINIA</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC CANCER</b><br>Due to (or as a consequence of):<br><b>b. LIVER CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Due to (or as a consequence of): |  |   |   |  | Approximate Interval Between Onset and Death<br><b>1 MONTH</b><br><b>2 MONTHS</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL FAILURE.</b><br><b>SEVERE MALNUTRITION</b><br><b>PLEURAL EFFUSION</b>  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D2A994</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 11, 1996</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARK T. BIRNS, MD - 9711 MEDICAL CENTER DRIVE #308 - ROCKVILLE, MARYLAND 20850</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>   |  | 32. Registrar's Signature<br>   |   |  |  |

State Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a discussion of the experimental design, the data collection procedures, and the statistical methods used to analyze the data.

The third part of the report is a discussion of the results of the study. This includes a presentation of the data and a discussion of the findings. The fourth part of the report is a conclusion and a discussion of the implications of the study. This includes a summary of the main findings and a discussion of the limitations of the study and the need for further research.

The fifth part of the report is a list of references. This includes a list of the books, articles, and other sources that were used in the study. The sixth part of the report is an appendix. This includes a list of the tables and figures that are included in the report.

The seventh part of the report is a list of abbreviations. This includes a list of the abbreviations that are used in the report. The eighth part of the report is a list of symbols. This includes a list of the symbols that are used in the report.

The ninth part of the report is a list of definitions. This includes a list of the definitions that are used in the report. The tenth part of the report is a list of acknowledgments. This includes a list of the people and organizations that provided assistance during the study.

The eleventh part of the report is a list of footnotes. This includes a list of the footnotes that are included in the report. The twelfth part of the report is a list of appendices. This includes a list of the appendices that are included in the report.

The thirteenth part of the report is a list of references. This includes a list of the books, articles, and other sources that were used in the study. The fourteenth part of the report is an appendix. This includes a list of the tables and figures that are included in the report.

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State of Maryland / Department of Health and Mental Hygiene

96 21905

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><u>Frederick S. Grubbs</u>   |  |   |  | 2. Date of Death<br>Month <u>07</u> Day <u>09</u> Year <u>1996</u>  |  | 3. Time of Death<br><u>0632</u>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><u>SHADY GROVE ADVENTIST HOSPITAL</u>  |  |   |  | 4b. City, Town, or Location of Death<br><u>ROCKVILLE</u>  |  | 4c. County of Death<br><u>MONTGOMERY</u>                                |  |
| Funeral<br>Director                           | 5. Social Security Number<br><u>220-50-9454</u>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>50</u> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><u>Apr 25, 1946</u>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><u>W.Va</u>  |  | 10a. State<br><u>Md</u>   |  | 10b. County<br><u>Montgomery</u>  |  | 10c. City, Town or Location<br><u>Poolesville</u>                       |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><u>19860 Beatriz Ave,</u>   |  | 10f. Zip Code<br><u>20837</u>   |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>                          |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><u>12th Grade</u>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Dental Lab Tech.</u>  |  | 16b. Kind of Business/Industry<br><u>Dentistry</u>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>Gladstone E. Grubbs</u>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Margaret F. Manuel</u>  |  | 19a. Informant's Name/Relationship (Type, Print) (Wife)<br><u>Mrs Linda F. Grubbs</u>   |  |   |  |
| Physician<br>/Medical<br>Examiner             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>19860 Beatriz Ave, Poolesville, Md #20837</u>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Metropolitan Crematory 7/12 Alexandria, Va</u>   |  | 20c. Location - City or Town, State                                     |  |
|   | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>  |  | 22. Name and Address of Facility<br><u>Snowden Funeral Home P.A. 20850 Rockville, Md</u>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><u>Inferior-posterior wall myocardial infarction</u><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____               |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  |
| State Registrar                               | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><u>M</u>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred                                       |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |
| Division of Vital Records, P.O. Box 68760,    | 29b. Signature and title of certifier<br><u>[Signature]</u>  |  | 29c. License number<br><u>D42110</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>July 9, 1996</u>  |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>DANIEL LEONARD CHAFFIN III 15225 SHADY GROVE ROAD ROCKVILLE, MARYLAND 20850</u>                       |  | 31. Date filed (Month, Day, Year)<br><u>JUL 12 1996</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21906

## Certificate of Death

Reg. No.

|   |  |   |   |  |   |   |  |  |
|---|--|---|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RUBY GRIFFITH</b>   |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>9</b> Year <b>96</b>   |   | 3. Time of Death<br><b>1403</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ATLANTIC GENERAL HOSPITAL</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>BERLIN</b>   |   | 4c. County of Death<br><b>WORCESTER</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>235-12-1793</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs. | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 22, 1920</b>  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                    |
|   | Usual Residence of Decedent  |   |   |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>15107 Interlochen Drive</b>   |   |   |  | 10f. Zip Code<br><b>20906</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4+</b>   |   |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Clayton Foltz</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hazel Chandler</b>  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas C. Griggin / Son</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18506 Lace Wing Place, Olney, Maryland 20832</b>  |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Norbeck Memorial Park</b>  |  | Date<br><b>7/12/96</b>  |   | 20c. Location - City or Town, State<br><b>Olney, Maryland</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Alan J. Donnell</b>  |   |   |  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home<br/>11800 New Hampshire Avenue<br/>Silver Spring, Maryland 20904</b>  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>anoxic encephalopathy</b><br>Due to (or as a consequence of):<br>b. <b>myocardial infarction</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>3 days</b> |   |   |  |   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |  |   |   |  |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                   |  |  |
|   |  |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how Injury occurred                |   |   |  |  |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Chintre two medical doctor</b>  |   | 29c. License number<br><b>D0050605</b>           |   | 29d. Date signed (Month, Day, Year)<br><b>July 9, 96</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>9733 Healthway Drive Berlin Md 21811</b>   |  |   |   |  |   |   |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>  |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

96 21907

Item 10a,b,c,d,e,f per informant 4-2-97 rja

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |  |
|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Maude Ellen Groves   |   |   | 2. Date of Death<br>Month Day Year<br>July 10, 1996  |  | 3. Time of Death<br>8:40 PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>PHYSICIANS MEMORIAL HOSPITAL   |   |   | 4b. City, Town, or Location of Death<br>LAPLATA  |  | 4c. County of Death<br>CHARLES   |  |
| Funeral<br>Director   | 5. Social Security Number<br>220-50-9742   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>99 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>APRIL 8, 1897   |
|   | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10e. State<br>Maryland   |   | 10b. County<br>Charles  |  | 10c. City, Town or Location<br>STAMFORD  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|   | 10f. Street and Number<br>3065 Old Washington Rd.<br>144 HIGHLINE TRAIL  |   | 10i. Zip Code<br>06902  |  | 10g. Citizen of What Country?<br>UNITED STATES   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5 College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOUSEWIFE                                |  | 16b. Kind of Business/Industry<br>OWN HOME   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>BENJAMIN FRANKLIN HARDESTY  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY ELLEN SWANN  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>DORIS E. MURRAY/DAUGHTER   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>144 HIGHLINE TRAIL, STAMFORD, CONN. 06902 |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ST. PETER'S CEMETERY  |  | 20c. Location - City or Town, State<br>JULY 15 WALDORF, MARYLAND   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>MARK G. BROHAWN M-00053   |   | 22. Name and Address of Facility<br>THE HUNTT FUNERAL HOME, INC.,<br>P.O. BOX 156 WALDORF, MARYLAND 20604   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Advanced Aortic Stenosis<br>Due to (or as a consequence of):<br>c. Atherosclerosis<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>[Signature]  |  | 29c. License number<br>D-20629  |   | 29d. Date signed (Month, Day, Year)<br>7/11/96   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>GEORGE WATHEM, MD 11345 Pembroke Square Suite 103 Waldorf, MD 20603   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 15 1996  |  | 32. Registrar's Signature<br>[Signature]  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21908  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FLORENCIA GASCON

2. Date of Death

Month Day Year  
July 12, 1996

3. Time of Death

3:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Clinton

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

212-04-4392

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 10, 1919

9. Birthplace (State or Foreign Country)

PHILLIPINES

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE

10c. City, Town or Location

CLINTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6107 BUCKLER ROAD

10f. Zip Code

20735

10g. Citizen of What Country?

PHILLIPINES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SEGUNDO GASCON

18. Mother's Name (First, Middle, Maiden Surname)

SABENA DeGUZMAN

19a. Informant's Name/Relationship (Type, Print)

MARIA GABRIEL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CREMATORY 7-16-96 ALEXANDRIA, VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael Brown

22. Name and Address of Facility

RAYMOND FUNERAL SERVICE  
LA PLATA, MARYLAND 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Insufficiency  
Due to (or as a consequence of):  
b. Chronic Interstitial lung disease  
Due to (or as a consequence of):  
c.  
Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

5 days  
20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sam Tellawi

29c. License number

D34 274

29d. Date signed (Month, Day, Year)

7.12.96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ESSAM TELLAWI M.D.

7700 Old Branch Ave. Clinton, Md.

31. Date filed (Month, Day, Year)

JUL 16 1996

32. Registrar's Signature

John Anderson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



96 21909

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |   |  |
|--|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Charlotte May Gardner  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 14, 1996  |  | 3. TIME OF DEATH<br>10:00 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-03-6851   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>85 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sep 12, 1910   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>St. Mary's Nursing Center  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Leonardtown   |  | 9c. COUNTY OF DEATH<br>St. Mary's   |  |
| RESIDENCE OF DECEDENT  |  |  |   |  |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>St. Mary's  |   | 10c. CITY, TOWN OR LOCATION<br>Leonardtown   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>Cedar Lane Apartments #2112  |  |  |   | 10f. ZIP CODE<br>20650   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th Grade  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Secretary   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Life Insurance Company   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Bennett Gardner   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Grace Bennett Gill  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Richard S. Combs   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>39115 Deer Lane, Mechanicsville, MD 20659   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Our Lady's Cemetery 7/18/96   |   | 20c. LOCATION — City or Town, State<br>Leonardtown, MD   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael L. Gardiner</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Respiratory Failure</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <i>Chronic Obstructive Pulmonary Disease</i><br>c. <i>Left Pulmonary Arteriovenous Conduit</i> |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br><i>2 yrs</i><br><i>15 yrs</i><br><i>1 year</i>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Peptic Ulcer Disease</i>  |  |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |   |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Gil Ernesto T. Del Los Reyes, M.D.</i>   |  |  |   | 29c. LICENSE NUMBER<br><i>AN677</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>16/Jul/96</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (FROM 27) (Type, Print)<br>Gil Ernesto T. Del Los Reyes, M.D. Hollywood, MD 20636  |  |  |   |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 18 1996   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |   |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21910

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |  |  |
|--|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Katherine RICHART Harter</b>                             |   |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>4</b> Year <b>1996</b> |  | 3. Time of Death<br><b>0507</b>                        |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>            |  | 4c. County of Death<br><b>MONTGOMERY</b>               |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-40-7416</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.                    |  | 8. Date of Birth (Month, Day, Year)<br><b>4-3-1909</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>   |   | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Montgomery</b>                                    |  | 10c. City, Town or Location<br><b>Rockville</b>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>11909 Old Bridge Rd.</b>   |  | 10f. Zip Code<br><b>20852</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> Collage (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  | 16b. Kind of Business/Industry<br><b>Home</b>  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Theodore Frederick Richart</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Suydam</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara H. Zanner/Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8 Montgomery Ave. Gaithersburg, Md. 20877</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |  | Data<br><b>7/8/96</b>  |   | 20c. Location - City or Town, State<br><b>Rockville. Md.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Michael D. Gibbons</b>   |   |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home<br/>10 East Deer Park Drive Gaithersburg, Md. 20877</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CARDIAC ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  |  |
| Approximate Interval Between Onset and Death<br><b>MINUTES</b>   |   |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PANCREATITIS</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br><b>John Herzog MD</b>  |  | 29c. License number<br><b>D 44293</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>July 4, 1996</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL M. HERZIG 2121 Medical Park Drive #6 Silver Spring MD 20902</b>  |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>  |   | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21911

|  |   |   |   |                                 |  |
|--|---|---|---|---------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Glenn Goodwin Haycraft</b>   |   | 2. Date of Death<br>Month <b>July</b> Day <b>8</b> Year <b>1996</b>   |                                 | 3. Time of Death<br><b>2:40 a.m.</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Washington Adventist Hospital</b>  |   | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>  |                                 | 4c. County of Death<br><b>Montgomery</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-26-7707</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 25, 1911</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Texas</b>  |                                 |  |
| To Be Completed by<br>Funeral Director   | Usual Residence of Decedent   |   | 10a. State<br><b>Maryland</b>   |                                 | 10b. County<br><b>Montgomery</b>   |
|  | 10c. City, Town or Location<br><b>Silver Spring</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                 |  |
|  | 10e. Street and Number<br><b>200 Quaint Acres Drive</b>   |   | 10f. Zip Code<br><b>20904</b>   |                                 | 10g. Citizen of What Country?<br><b>United States</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>5+</b>                         |                                 | 16. Kind of Business/Industry<br><b>Federal Government</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Isaac Haycraft</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Daisy Sylvester</b>   |                                 |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dorothy P. Haycraft - Wife</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 Quaint Acres Drive, Silver Spring, Maryland 20904</b> |                                 |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |                                 | 20c. Location - City or Town, State<br><b>Rockville, Maryland</b>  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home, Inc.<br/>11800 New Hampshire Avenue, Silver Spring, MD 20904</b>                           |                                 |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Causa (Final disease or condition resulting in death)<br><b>a. Ca Pancreas.</b><br>Dua to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last<br><b>b. Dua to (or as a consequence of):</b><br><b>c. Dua to (or as a consequence of):</b><br><b>d.</b> |   | Approximate Interval Between Onset and Death<br><b>2 months</b>   |                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |   | 23b. Did tobacco use contribute to the causa of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |                                 |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of causa of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |                                 |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                 |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b> | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |   |                                 |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |                                 |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.  |   | 29b. Signature and title of certifier<br>   |   |                                 |  |
| 29c. License number<br><b>D14141</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>7-8-96</b>  |   |                                 |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Robert A. Smith M.D. 7610 Carroll Ave. Takoma Park Md 20912</b>   |   |   |   |                                 |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>   |   | 32. Registrar's Signature<br>   |                                 |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 21912

Reg. No.

|  |  |                            |   |   |  |  |  |   |   |  |  |
|--|--|----------------------------|---|---|--|--|--|---|---|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>TERRANCE HOPKINS</b>                                  |                            |   |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>12</b> Year <b>1996</b> |  |   | 3. Time of Death<br><b>4:27 P.M.</b>                        |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SAINT JOSEPH MEDICAL CENTER</b> |                            |   |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON, MARYLAND</b>      |  |   | 4c. County of Death<br><b>BALTIMORE</b>                     |  |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>212-70-3417</b>  |                            | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>37</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 10 1958</b>                       |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |  |
|  | Usual Residence of Decedent  |                            |   |   |  |  |  |   |   |  |  |
| 10e. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>CITY</b> |   | 10c. City, Town or Location<br><b>BALTIMORE</b> |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
| 10e. Street and Number<br><b>1314 McCULLOH STREET</b>  |  |                            |   |   | 10f. Zip Code<br><b>21217</b>  |  |  | 10g. Citizen of What Country?<br><b>US</b>  |   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>2 yrs.</b>  |  |                            |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CONSULTANT</b>   |  |  | 16b. Kind of Business/Industry<br><b>SELF EMPLOYED</b>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>FRANK C. HOPKINS, JR.</b>  |  |                            |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>VIRGINIA NICK</b>  |  |  |   |   |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>VIRGINIA HOPKINS (MOTHER)</b>   |  |                            |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6023 SHADY SIDE RD, SHADY SIDE, MD. 20764</b>  |  |  |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. MATTHEWS CHURCH CEME.</b>  |   |  | Data<br><b>7/17/96</b>   |  | 20c. Location - City or Town, State<br><b>SHADY SIDE, MD.</b>   |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                            |   |   | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>   |  |  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. <b>PNEUMONIA</b><br/>Due to (or as a consequence of):</p> <p>b. <b>HUMAN IMMUNODEFICIENCY VIRUS INFECTION</b><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____<br/>Due to (or as a consequence of):</p> </div> </div> |  |                            |   |   |  |  |  |   |   | Approximate interval Between Onset and Death<br><b>2 DAYS</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                            |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|  |  |                            |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |                            | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred                           |  |  |
|  |  |                            | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |                            |   |   |  |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br>   |  |                            |   |   | 29c. License number<br><b>D30263</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>07-12-96</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FRANCIS T. KHOO, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204</b>   |  |                            |   |   |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 15 1996</b>  |  |                            | 32. Registrar's Signature<br>  |   |  |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21913

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |   |
|--|---|--|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>BARBARA RUTH HORWITZ  |  |   |  | 2. Date of Death<br>Month Day Year<br>JULY 7, 1996   |  | 3. Time of Death<br>10:30 PM                                     |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>5711 BALSAM GROVE COURT   |  |   |  | 4b. City, Town, or Location of Death<br>N. BETHESDA  |  | 4c. County of Death<br>MONTGOMERY                                |   |
| Funeral<br>Director  | 5. Social Security Number<br>579-46-3422  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>64 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>MARCH 3, 1932   |  | 9. Birthplace (State or Foreign Country)<br>DISTRICT OF COLUMBIA  |
|  | Usual Residence of Decedent   |  |   |  |  |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND  | 10b. County<br>MONTGOMERY  | 10c. City, Town or Location<br>N. BETHESDA  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |
|  | 10e. Street and Number<br>5711 BALSAM GROVE COURT   |  |   | 10f. Zip Code<br>20852   |  | 10g. Citizen of What Country?<br>UNITED STATES   |  |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+) 4  |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>PARTY COORDINATOR                        |  |  | 16b. Kind of Business/Industry<br>ENTERTAINMENT  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br>SIDNEY EHRLICH   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>DOROTHY SACHS   |  |  |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>SCOTT HORWITZ (SON)   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>18352 ALLSPICE DRIVE - GERMANTOWN, MARYLAND 20874 |  |  |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ADAS ISRAEL CEMETERY  |  | Data<br>7/10/96  | 20c. Location - City or Town, State<br>WASHINGTON, D.C.  |  |   |
|  | 21. Signature of Funeral Service Licensee   |  |   | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852                   |  |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Acute Myocardial Infarction</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br>Immediate   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>HYPERTENSION</u>   |  |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier  |   | 29c. License number<br>D1K921  |  | 29d. Date signed (Month, Day, Year)<br>7/8/96  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>5225 ROCKS HILL RD, S.E. #1, BETHESDA, MD 20814  |   |  |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>JUL 09 1996   |   | 32. Registrar's Signature<br>Julia Davidson-Randall  |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21914

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>ROY R. HUNT  |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br>JULY 05 1996  |  | 3. Time of Death<br>23:15  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Washington Adventist Hospital  |  |   |  |  |  | 4b. City, Town, or Location of Death<br>Takoma Park   |  | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director                              | 5. Social Security Number<br>579-03-7081   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>84 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>July 5, 1912   |  | 9. Birthplace (State or Foreign Country)<br>Virginia   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director              | 10e. State<br>Maryland   |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Spencerville  |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 10e. Street and Number<br>16110 Oak Hill Road  |  |   |  | 10f. Zip Code<br>20868   |  | 10g. Citizen of What Country?<br>USA  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+) 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Contractor   |  |  |  | 16b. Kind of Business/Industry<br>Building  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>David J. Hunt   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sally Satisfythe                                 |  |  |  |
| To Be Completed by Physician/Medical Examiner    | 19e. Informant's Name/Relationship (Type, Print)<br>Sharon Harriger / Daughter   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16110 Oak Hill Road, Spencerville, Maryland 20868   |  |   |  |  |  |
|  | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Colesville Cemetery   |  | Date<br>7/9/96   |  | 20c. Location - City or Town, State<br>Silver Spring, Maryland  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Alan J. Donnell   |  |   |  | 22. Name and Address of Facility Hines-Rinaldi Funeral Home<br>11800 New Hampshire Avenue<br>Silver Spring, Maryland 20904   |  |   |  |  |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Ischemic Vascular Accident</u><br>Due to (or as a consequence of):<br>b. <u>Sudden Atherosclerotic Ischemic Vascular</u><br>Due to (or as a consequence of):<br>c. <u>Disease</u><br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><u>6 days</u><br><u>10-15 years</u> |  |   |  |  |  |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Deep Venous Thromboses bilaterally</u><br><u>Coronary Arteriosclerosis left below</u><br><u>knee amputation, right above knee amputation</u>  |  |   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28e. Date of Injury (Month, Day, Year)<br>N/A   |  | 28b. Time of Injury<br>N/A M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           |  | 28d. Describe how Injury occurred  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>N/A  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
|  | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |  |  |  |
| State Registrar                                  | 29b. Signature and title of certifier<br>[Signature]   |  |   |  | 29c. License number<br>26265   |  | 29d. Date signed (Month, Day, Year)<br>7/6/96   |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>7610 Carroll Ave Suite B30, Takoma Park Md 20912   |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 10 1996 |  | 32. Registrar's Signature<br>John Davidson-Randall |   |  |  |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21915

## Certificate of Death

Reg. No.

|  |  |  |  |  |  |   |   |  |
|--|--|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH THOMAS HEFFRON</b>   |  |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>11</b> Year <b>1996</b>   |   | 3. Time of Death<br><b>12:34 PM</b>                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Montgomery General Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Olney</b>   |   | 4c. County of Death<br><b>Montgomery</b>                                |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-12-9895</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 13, 1909</b>            |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Buffalo, NY</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>   |   | 10c. City, Town or Location<br><b>Silver Spring</b>                     |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3514 Tarkington Lane</b>  |  | 10f. Zip Code<br><b>20906</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1942-1946</b>    |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Personnel Director</b> |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph A. Heffron</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mae Durkin</b>   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty J. Heffron</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3514 Tarkington Lane, Silver Spring, MD 20906</b>  |   |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                |  | 20c. Location - City or Town, State<br><b>7/12/96 Alexandria, Virginia</b>   |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Andrew J. Cole</i>   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd. W. Silver Spring, MD 20901</b>   |  |  |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Refractory Failure Secondary to Emphysema</i><br>Due to (or as a consequence of):<br>b. <i>Pneumonia</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |   |   |  |
|  | Approximate Interval Between Onset and Death<br><i>2 weeks</i><br><i>2 weeks</i>   |  |  |  |  |   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |  |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |   |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year) |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|  |  | 28d. Describe how injury occurred      |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br><i>W. A. Lewis M.D.</i>   |  |  |  | 29c. License number<br><i>D30908</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>July 11, 1996</i>                                 |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>3305 North Laurel Road, Silver Spring, Maryland 20906</i>   |  |  |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>  |  |  |  | 32. Registrar's Signature<br><i>J. Davidson-Pendell</i>                      |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21916

Certificate of Death

Reg. No.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Edward Newton Hall</b>   |   | 2. Date of Death<br>Month <b>July</b> Day <b>6</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>9:45 pm</b>          |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Bel Air Convalescent and Rehab. Center</b> |   | 4b. City, Town, or Location of Death<br><b>Bel Air</b>   |  | 4c. County of Death<br><b>Harford</b>       |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-05-7725</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.              |
|  | 8. Date of Birth (Month, Day, Year)<br><b>01/23/1903</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  |   |
| Usual Residence of Decedent  |   |   |  |  |   |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Bel Air</b>  |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |   |
| 10e. Street and Number<br><b>26 North Hickory Avenue</b>   |   |   | 10f. Zip Code<br><b>21014</b>  |  | 10g. Citizen of What Country?<br><b>USA</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1 year</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accounting</b>                    |  | 16b. Kind of Business/Industry<br><b>Self-employed</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Clay Hall</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virgle Eugenia Holmes</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Adams (Friend)</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1401 Gunston Rd. Bel Air, MD 21015</b> |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Darlington Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>07/09/96 Darlington, MD</b>  |   |
| 21. Signature of Funeral Service Licensee<br><b>Madelyn Mitchell Shant</b>   |   | 22. Name and Address of Facility<br><b>Mitchell-Smith Funeral Home<br/>123 S. Washington St. Havre de Grace MD</b>                                |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Chronic Pancreatitis</b><br>Due to (or as a consequence of):<br>c. <b>Cerebral degeneration</b><br>Due to (or as a consequence of):<br>d. <b>Dementia</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)<br><b>NA</b>  |  | 28b. Time of Injury<br><b>NA</b> M   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred<br><b>NA</b>  |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>NA</b>  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>NA</b>   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |   |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |   | 29c. License number<br><b>D38885</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7. 7. 96</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ALAN SPANUS 615 W. MACPHERSON BLVD BALTIMORE MD 21014</b>   |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 9 1996</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21917

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |   |  |
|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MARY Helen HENDERSON  |   |  |  | 2. Date of Death<br>Month Day Year<br>July 14 1996   |  | 3. Time of Death<br>5.00 P.M.   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>St. Mary's Hospital   |   |  |  | 4b. City, Town, or Location of Death<br>Leonardtown  |  | 4c. County of Death<br>St. Mary's   |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-34-0269  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>67 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>May 6, 1929  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |   | 10a. State<br>Maryland   |  | 10b. County<br>St. Mary's  |  | 10c. City, Town or Location<br>Ridge  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br>P.O. Box 323   |  | 10f. Zip Code<br>20680   |  | 10g. Citizen of What Country?<br>U.S.A.   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11th Grade  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cook  |  | 16b. Kind of Business/Industry<br>Marina   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Warren Miton Adams   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Elizabeth Hewitt   |  |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Russell Henderson   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>70 Lord Calvert Mobile Home, Lexington Park, MD 20653   |  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory   |  | Date<br>7/15/96  |  | 20c. Location - City or Town, State<br>Alexandria, VA   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Michael L. Gardiner</i>   |   | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650  |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Complete heart block → Ventricular Fibrillation</i><br>Due to (or as a consequence of):<br>b. <i>Cardiomyopathy</i><br>Due to (or as a consequence of):<br>c. <i>Acute Respiratory Distress Syndrome</i><br>Due to (or as a consequence of):<br>d. <i>Hypokalemia</i> |   | Approximate Interval Between Onset and Death<br>1 hr.<br>2+ yrs.<br>6 days<br>2 days   |  |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypothyroidism</i><br><i>shock liver syndrome</i>  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>John F. Fenwick</i> |  | 29c. License number<br>D01280                    |  | 29d. Date signed (Month, Day, Year)<br>7.15.96 |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. JOHN F. FENWICK<br>LEONARDTOWN, MD. 20650   |   | 31. Date filed (Month, Day, Year)<br>JUL 16 1996                |  | 32. Registrar's Signature<br><i>John Fenwick</i> |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

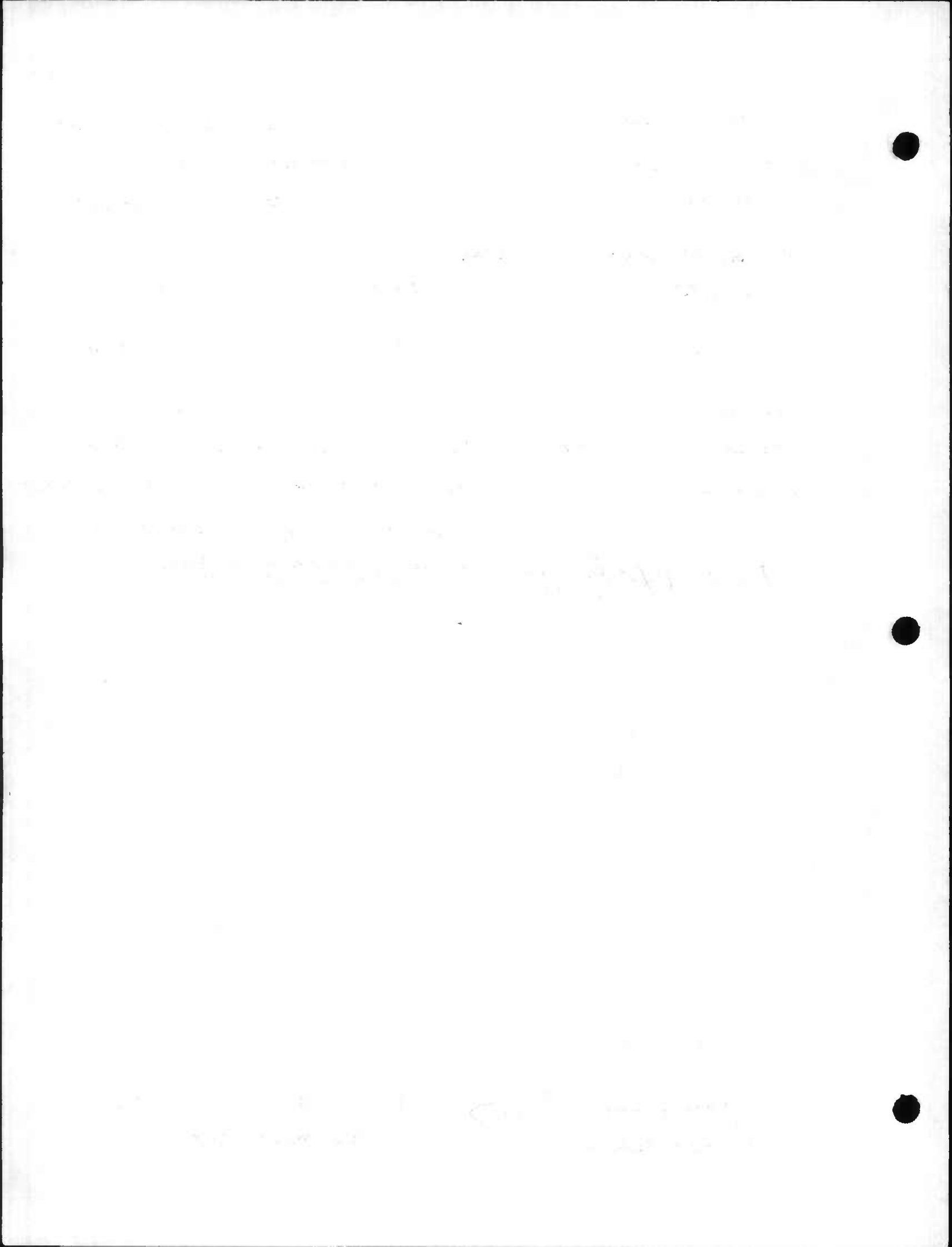
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





96-3723-037  
CIP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

UNKNOWN

State of Maryland / Department of Health and Mental Hygiene

96

2969148

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |                                      |  |                                |  |  |  |  |
|---|--|--|--------------------------------------|--|--------------------------------|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Lawrence Frederick Hoehl  |  |  |                                      | 2. Date of Death<br>Month Day Year<br>JULY 4, 1996   |                                | 3. Time of Death<br>9:53PM   |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br>MARYLAND ROUTE #235 BEFORE GUNSTON ROAD CALIFORNIA  |  |  |                                      | 4b. City, Town, or Location of Death<br>ST. MARY'S   |                                | 4c. County of Death<br>ST. MARY'S  |  |  |  |
| 5. Social Security Number<br>146-36-1281  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>51 | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>Dec. 20, 1944   |  |  |  |
| 9. Birthplace (State or Foreign Country)<br>New Jersey  |  |  |                                      |  |                                |  |  |  |  |
| Usual Residence of Decedent   |  |  |                                      |  |                                |  |  |  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>St. Mary's  |                                      | 10c. City, Town or Location<br>Lexington Park  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br>21498 Amy Road  |  |  |                                      | 10f. Zip Code<br>20653   |                                | 10g. Citizen of What Country?<br>USA   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 62-66  |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  |  |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer   |                                | 16b. Kind of Business/Industry<br>Construction   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Frederick Carl Hoehl   |  |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Runiak   |                                |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Carol A. Hoehl Wife   |  |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>21498 Amy Rd. Lexington Park, Md. 20653   |                                |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory Inc.   |                                      | Date<br>7/10/96  |                                | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>[Signature]  |  |  |                                      | 22. Name and Address of Facility<br>Brinsfield Funeral Home PA<br>P.O. Box 279 Leonardtown, Md. 20650  |                                |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Multiple Myeloma<br>Due to (or as a consequence of):<br><br>f. Due to (or as a consequence of):<br><br>g. Due to (or as a consequence of):<br><br>h. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |                                      |  |                                |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                                      |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|   |  |  |                                      |  |                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   |  |  |                                      |  |                                |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY |                                      |  |                                |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br>7-4-96  |                                      | 28b. Time of Injury<br>2:50 M  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>pedestrian struck by 2 autos  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>STREET   |                                      |  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Rte. 235, North  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>[Signature]   |                                      | 29c. License number<br>O.C.M.E.  |                                | 29d. Date signed (Month, Day, Year)<br>JULY 5, 1996  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JASON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201  |  |  |                                      |  |                                |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 11 1996  |  |  |                                      | 32. Registrar's Signature<br>[Signature]   |                                |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21919

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Cecilia Jones

2. Date of Death

Month Day Year  
July 9, 1996

3. Time of Death

6:07 PM

4a. Facility Name (If not institution, give street and number)

Presidential Woods Nursing Home

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

183-20-6218

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
March 12, 1912

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

935 Bonifant Street

10f. Zip Code

20910

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Technician

16b. Kind of Business/Industry

Electric

17. Father's Name (First, Middle, Last)

Frank Konkus

18. Mother's Name (First, Middle, Maiden Surname)

Anna Mitroka

19a. Informant's Name/Relationship (Type, Print)

Angeline Nesgoda

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

935 Bonifant Street Silver Spring, Maryland 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/12/96

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

John L. Chapel

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Sil. Spr., Maryland 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1/2 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M. S. Noyes

29c. License number

D-17874

29d. Date signed (Month, Day, Year)

7-11-96

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SANKARAN M. NAYAR, MD. 3717 - 38th AVE BRENTWOOD, MD 20722

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 1996

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

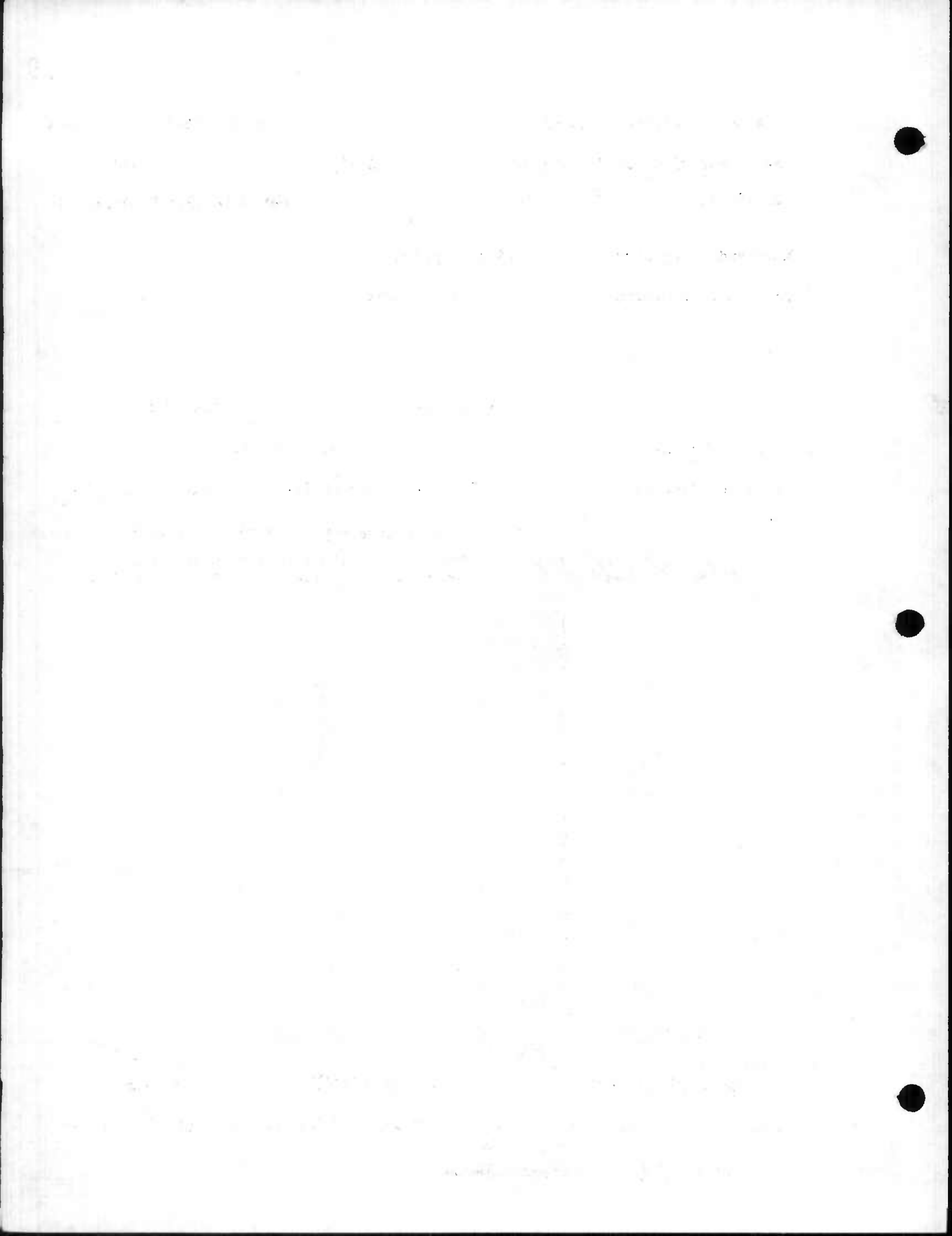
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



96-3771-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

B.K.S ITEMS: 23 PART I, II, 27, State of Maryland / Department of Health and Mental Hygiene

28a-f, PER MEO FILM g-737 7/26/96 t.t

## Certificate of Death

Reg. No.

96 21920

|  |   |  |   |   |  |  |  |
|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>VINCENT BURCH JONES</b>  |  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>07</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>2130 PM</b>                             |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>12523 ATHERTON DRIVE</b>   |  |   | 4b. City, Town, or Location of Death<br><b>WHEATON</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>                       |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-74-8147</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                       | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>April 5, 1957</b> | 9. Birthplace (State or Foreign Country)<br><b>Kentucky</b>  |
|  | Usual Residence of Decedent   |  |   |   |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Silver Spring</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|  | 10e. Street and Number<br><b>3603 Jeffry Street</b>   |  |   | 10f. Zip Code<br><b>20906</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                    |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>  |   | 16b. Kind of Business/Industry<br><b>N/A</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George Daniel Jones</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Shirley Ruth Harrison</b>   |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>George D. Jones</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3603 Jeffry Street, Silver Spring, MD 20906</b> |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |   | Date<br><b>7/11/96</b>   |  | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd. W. Silver Spring, MD 20901</b>                |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>NARCOTIC INTOXICATION</b><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SARCOIDOSIS</b>  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br><b>UNKNOWN</b>   |   | 28b. Time of Injury<br><b>UNKNOWN</b> M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 28d. Describe how Injury occurred<br><b>UNKNOWN</b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND IN BASEMENT APARTMENT (RESIDENCE)</b>  |   |  |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>12523 ATHERTON DRIVE</b>   |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>MONTGOMERY COUNTY, MD</b>  |   |  |  |  |
| State Registrar  | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |  |
|  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 8, 1996</b>   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Mary Ann A. Kowalski 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 1996</b>              |   | 32. Registrar's Signature<br> |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





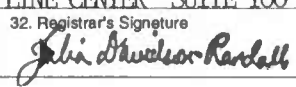
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State of Maryland / Department of Health and Mental Hygiene

96 21921

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |   |  |
|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MONTE DEAN KELLAR</b>  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 9, 1996</b>  |  | 3. Time of Death<br><b>11:18 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PHYSICIANS MEMORIAL HOSPITAL</b>   |   |  |  | 4b. City, Town, or Location of Death<br><b>LAPLATA</b>   |  | 4c. County of Death<br><b>CHARLES</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>234-56-8361</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>59</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 27, 1937</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b> |
|   | Usual Residence of Decedent   |   |  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Charles</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>40 Raymond Ave.</b>   |  | 10f. Zip Code<br><b>20640</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1955-1959</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                                      |  | 16b. Kind of Business/Industry<br><b>Self Employed</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Freeman R. Kellar</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Purdia Spencer</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley Kellar Wife</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as #10</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory July 11, 1996 Alexandria, Va.</b>                              |  | Date   |  | 20c. Location - City or Town, State   |  |
|   | 21. Signature of Funeral Service Licensee<br><br>M00668   |   | 22. Name and Address of Facility<br><b>Williams Funeral Home, P.A.<br/>Indian Head, Maryland</b>   |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. </b><br>Due to (or as a consequence of):<br><br><b>c. </b><br>Due to (or as a consequence of):<br><br><b>d. </b> |   |  |  |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |   |   |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred                                |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><br><b>Howard Haft MD</b>   |   |   |  | 29c. License number<br><b>D-27348</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/10/96</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>HOWARD HAFT MD 700 OLD LINE CENTER SUITE 100 WILDFORD MD. 20602</b>  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>   |   | 32. Registrar's Signature<br>  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Amended #17, 19b, MRT, 7/15/96, MRT, Montg. Cty.  
Amended #7, 7/12/96, MRT, Montg. Cty.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland Department of Health and Mental Hygiene  
Certificate of Death

96 21922

Reg. No.

|   |   |                           |  |   |  |  |   |  |  |  |  |
|---|---|---------------------------|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Joseph Franklin Kendall               |                           |  |   |  |  | 2. Date of Death<br>Month Day Year<br>July 9, 1996  |  |  | 3. Time of Death<br>9 AM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>7620 Maple Ave. |                           |  |   |  |  | 4b. City, Town, or Location of Death<br>Takoma Park |  |  | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director   | 5. Social Security Number<br>230-40-3994  |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br>57 58 Yrs. |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 11-1937 |  | 9. Birthplace (State or Foreign Country)<br>Washington D.C.      |  |  |
|   | Usual Residence of Decedent   |                           |  |   |  |  |   |  |  |  |  |
| 10a. State<br>MD  |   | 10b. County<br>Montgomery |  | 10c. City, Town or Location<br>Takoma Park  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br>7620 Maple Ave. Apt #101  |   |                           |  | 10f. Zip Code<br>20912  |  |  | 10g. Citizen of What Country?<br>U.S.A.             |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1957-to 1960 |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12   |   |                           |  | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Taxi Cab Driver  |  |  |   | 15b. Kind of Business/Industry<br>Transportation   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Frank J. Kendall   |   |                           |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dorothy R. Cole   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Toni L. Cobarrubias (Daughter)  |   |                           |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>401 west Ave. 37 Los Angeles CA 90065<br>Los Angeles  |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                           |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln crematory  |  |  |   | 20c. Location - City or Town, State<br>Fort Lincoln MD   |  | 20d. Date<br>7-12-1996   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |                           |  |   |  | 22. Name and Address of Facility<br>Hines Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute myocardial infarction<br>Due to (or as a consequence of):<br>b. Atherosclerotic Heart Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |                           |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br>10 months<br>years   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes mellitus<br>Atherosclerotic Cardiovascular Disease   |   |                           |  |   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                           |  |   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                           |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |                           |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how Injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                           |  | 29b. Signature and title of certifier<br>Alan Weinstein MD  |  |  |   | 29c. License number<br>009748 MD   |  | 29d. Date signed (Month, Day, Year)<br>7/11/96   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Alan Weinstein MD 10313 Georgia Ave Silver Spring MD 20902  |   |                           |  |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 12 1996  |   |                           |  | 32. Registrar's Signature<br>Julia Davidson-Randall   |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

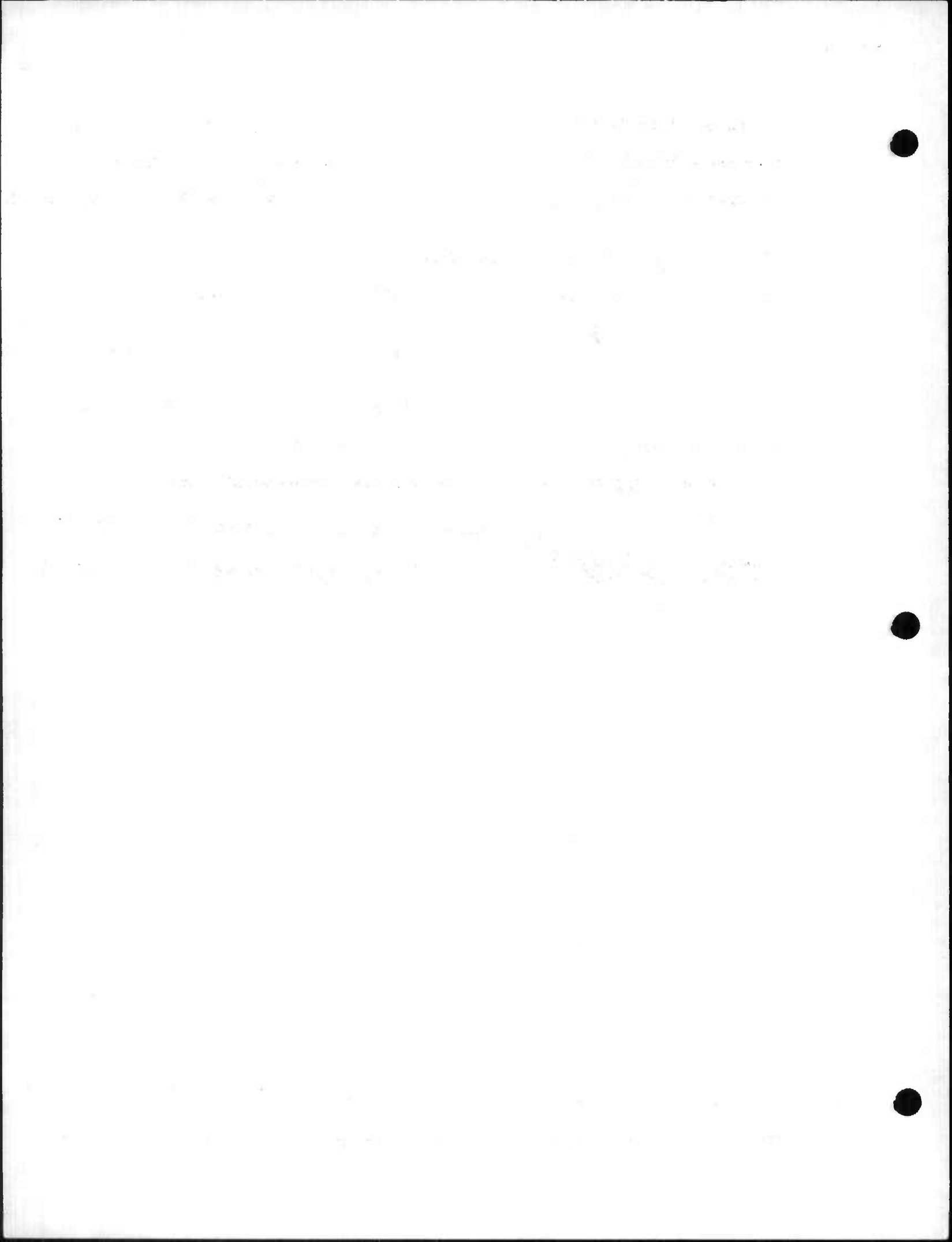
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

10

State  
Registrar




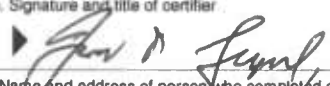

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21923

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |   |   |  |
|---|--|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MORRIS KALES</b>                            |   |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>11</b> , Year <b>1996</b> |   | 3. Time of Death<br><b>8:45 AM</b>                          |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>6408 MARJORY LANE</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>                |   | 4c. County of Death<br><b>MONTGOMERY</b>                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-40-6206</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.                       |   | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 26, 1910</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b>                                |   | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>MONTGOMERY</b>                                       |   | 10c. City, Town or Location<br><b>BETHESDA</b>              |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>6408 MARJORY LANE</b>  |  | 10f. Zip Code<br><b>20817</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                                       |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MATHEMATICIAN</b>   |  | 16b. Kind of Business/Industry<br><b>EDUCATION</b>   |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>LOUIS KALINSKY</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SOPHIE BERGMAN</b>   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROSE KALES (WIFE)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6408 MARJORY LANE - BETHESDA, MARYLAND 20817</b>   |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING DAVID MEMORIAL GDN.</b>   |  | Date<br><b>7/14/96</b>   |  | 20c. Location - City or Town, State<br><b>FALLS CHURCH, VIRGINIA</b>                        |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852</b>   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebrovascular disease</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>years</b> |  |   |  |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arteriosclerosis of heart disease</b><br><b>Diabetes Mellitus</b>  |  |   |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br> MD   |  | 29c. License number<br><b>MD 10200</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 11, 1996</b>  |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACK SEGAL, MD - 5454 WISCONSIN AVENUE #925 - CHEVY CHASE, MARYLAND 20815</b>  |  |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>   |  | 32. Registrar's Signature<br>  |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar

DHMH 16 Rev 6/95



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

96 21924

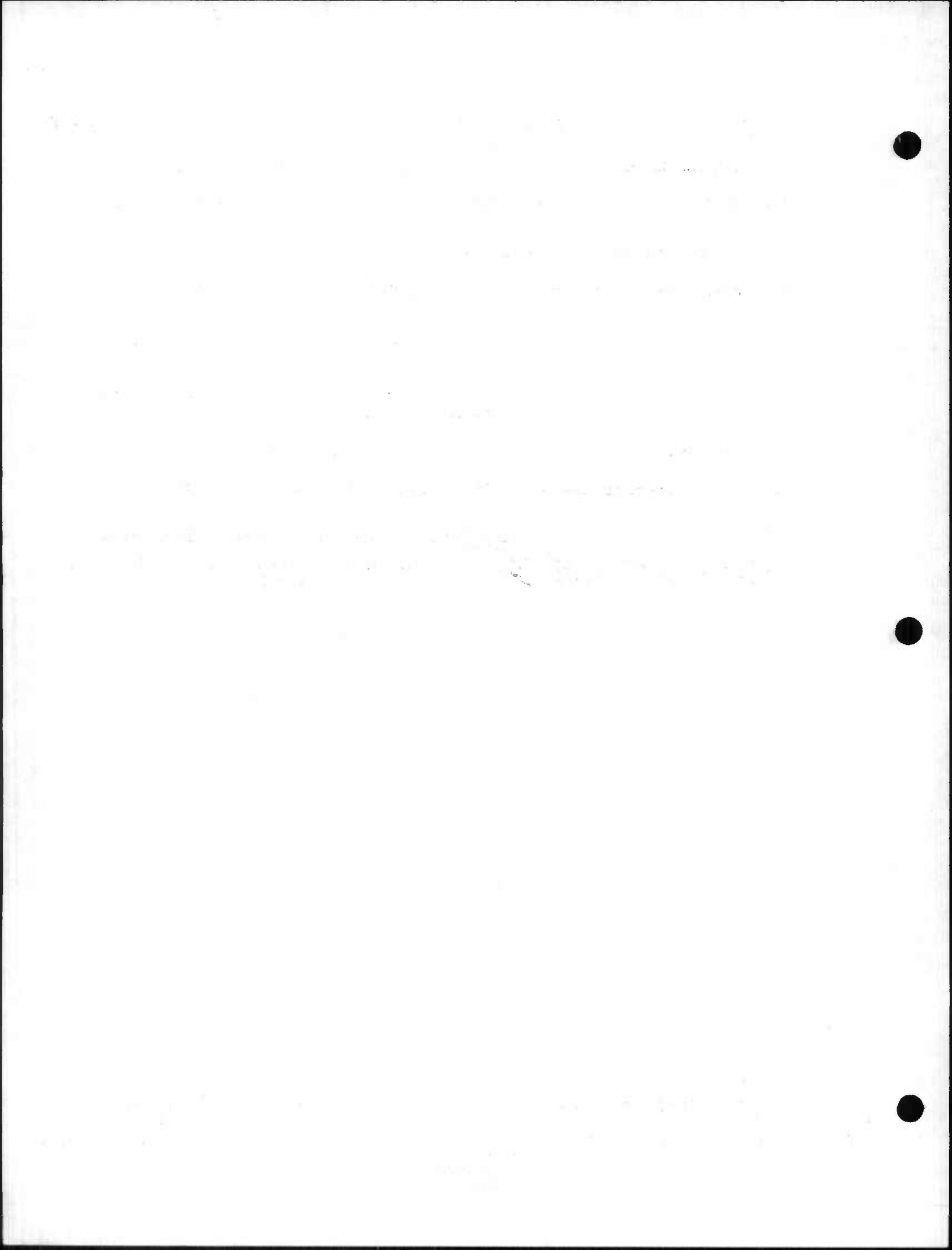
Reg. No.

|  |  |        |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
|--|--|--------|---|--------|---|--|--|---|--|---|--|--|--|--------|----------------------|----------------------------------|--|----------------------------------|---------------------|------|----------------------|----------------------------------|--|----|----------------------|--------|--|----------------------------------|--|----|----------------------|--------|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>GINA G KOROLAKIS</b>  |        |   |        |   | 2. Date of Death<br>Month <b>July</b> Day <b>11</b> Year <b>1996</b> |  | 3. Time of Death<br><b>9:42am</b>                                       |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |        |   |        |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>         |  | 4c. County of Death<br><b>Montgomery</b>                                |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>578-68-3214</b>  |        | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |        | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 4, 1931</b>                        |   | 9. Birthplace (State or Foreign Country)<br><b>Greece</b>                                      |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
|  | Usual Residence of Decedent  |        |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 10a. State<br><b>MD</b>  |  |        | 10b. County<br><b>Montgomery</b>  |        |   | 10c. City, Town or Location<br><b>Bethesda</b>                       |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 10e. Street and Number<br><b>7401 West Lake Terrace Apt. 701</b>   |  |        |   |        | 10f. Zip Code<br><b>20817</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  |        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |        |   |        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk LAW Dept.</b>   |  |  | 16b. Kind of Business/Industry<br><b>Marriott Inc.</b>                  |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 17. Father's Name (First, Middle, Last)<br><b>John Sporgitas</b>   |  |        |   |        | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Anna Karanastasis</b>   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anna Papageorgiou (Daughter)</b>  |  |        |   |        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9601 Cable Dr. Kensington, MD 20895</b>   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate Of Heaven Cemetery</b>  |        |   | Data<br><b>7-13-96</b>   |  | 20c. Location - City or Town, State<br><b>Silver Spring MD</b>          |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 21. Signature of Funeral Service Licensee  |  |        |   |        | 22. Name and Address of Facility<br><b>11800 New Hampshire Ave. Silver Spring, MD 20904</b>   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |        |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> <b>Immediate Cause (Final disease or condition resulting in death)</b><br/><br/> <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b> </td> <td style="width:60%; vertical-align: top;"> <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:75%;">Cardio Pulmonary Arrest</td> <td style="width:20%; text-align: center;">Sudden</td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">b.</td> <td>Respiratory Failure</td> <td style="text-align: center;">Days</td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">c.</td> <td>Metastatic Carcinoma</td> <td style="text-align: center;">Months</td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">d.</td> <td>Pancreatic Carcinoma</td> <td style="text-align: center;">Months</td> </tr> </table> </td> </tr> </table> |  |        |   |        |   |  |  |   |  | <b>Immediate Cause (Final disease or condition resulting in death)</b><br><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b> | <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:75%;">Cardio Pulmonary Arrest</td> <td style="width:20%; text-align: center;">Sudden</td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">b.</td> <td>Respiratory Failure</td> <td style="text-align: center;">Days</td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">c.</td> <td>Metastatic Carcinoma</td> <td style="text-align: center;">Months</td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">d.</td> <td>Pancreatic Carcinoma</td> <td style="text-align: center;">Months</td> </tr> </table> | a.   | Cardio Pulmonary Arrest  | Sudden |                      | Due to (or as a consequence of): |  | b.                               | Respiratory Failure | Days |                      | Due to (or as a consequence of): |  | c. | Metastatic Carcinoma | Months |  | Due to (or as a consequence of): |  | d. | Pancreatic Carcinoma | Months |
| <b>Immediate Cause (Final disease or condition resulting in death)</b><br><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b>  | <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:75%;">Cardio Pulmonary Arrest</td> <td style="width:20%; text-align: center;">Sudden</td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">b.</td> <td>Respiratory Failure</td> <td style="text-align: center;">Days</td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">c.</td> <td>Metastatic Carcinoma</td> <td style="text-align: center;">Months</td> </tr> <tr> <td></td> <td style="text-align: center;">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td style="text-align: center;">d.</td> <td>Pancreatic Carcinoma</td> <td style="text-align: center;">Months</td> </tr> </table> | a.     | Cardio Pulmonary Arrest   | Sudden |   | Due to (or as a consequence of):                                     |  | b.  | Respiratory Failure  | Days  |  | Due to (or as a consequence of):   |  | c.     | Metastatic Carcinoma | Months                           |  | Due to (or as a consequence of): |                     | d.   | Pancreatic Carcinoma | Months                           |  |    |                      |        |  |                                  |  |    |                      |        |
| a.   | Cardio Pulmonary Arrest  | Sudden |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
|  | Due to (or as a consequence of):   |        |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| b.   | Respiratory Failure  | Days   |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
|  | Due to (or as a consequence of):   |        |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| c.   | Metastatic Carcinoma   | Months |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
|  | Due to (or as a consequence of):   |        |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| d.   | Pancreatic Carcinoma   | Months |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| <table border="0" style="width:100%;"> <tr> <td style="width:70%; vertical-align: top;"> <b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b><br/> <b>- Renal Insufficiency</b><br/> <b>- Dehydration</b> </td> <td style="width:30%; vertical-align: top;"> <b>23b. Did tobacco use contribute to the cause of death?</b><br/> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown </td> </tr> <tr> <td style="vertical-align: top;"> <b>24a. Was an autopsy performed?</b><br/> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </td> <td style="vertical-align: top;"> <b>24b. Were autopsy findings available prior to completion of cause of death?</b><br/> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table>  |  |        |   |        |   |  |  |   |  | <b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b><br><b>- Renal Insufficiency</b><br><b>- Dehydration</b>   | <b>23b. Did tobacco use contribute to the cause of death?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  | <b>24a. Was an autopsy performed?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <b>24b. Were autopsy findings available prior to completion of cause of death?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
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| <b>24a. Was an autopsy performed?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | <b>24b. Were autopsy findings available prior to completion of cause of death?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No   |        |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |        |   |        | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |        | 28a. Date of Injury (Month, Day, Year)  |        | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how Injury occurred  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |        | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |        |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |        |   |        | 29c. License number<br><b>D-32332</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>07/11/96</b>                           |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Suresh K. Gupta 9801 Georgia Ave # 220 SILVER SPRING, MD 20909</b>  |  |        |   |        |   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>  |  |        |   |        | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |  |   |  |  |  |        |                      |                                  |  |                                  |                     |      |                      |                                  |  |    |                      |        |  |                                  |  |    |                      |        |

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
 To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21925

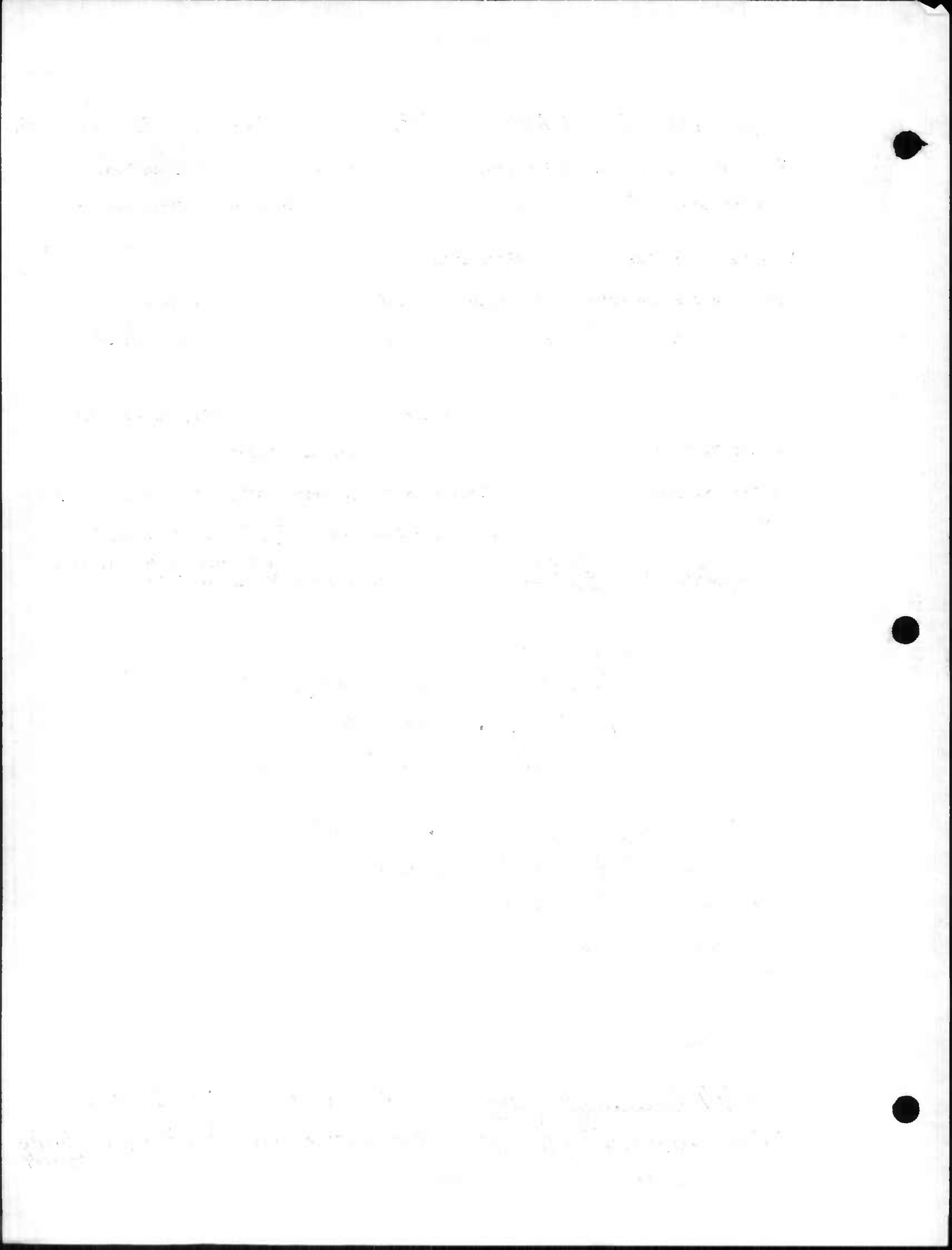
## Certificate of Death

Reg. No.

|   |  |  |   |                                      |   |  |   |  |
|---|--|--|---|--------------------------------------|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ARTHUR E KANE SR.</b>   |  |   |                                      | 2. Date of Death<br>Month <b>JULY</b> Day <b>1</b> Year <b>96</b>   |  | 3. Time of Death<br><b>12:15 PM</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Southern Maryland Hospital Center</b>   |  |   |                                      | 4b. City, Town, or Location of Death<br><b>Clinton</b>  |  | 4c. County of Death<br><b>Prince George</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>056-05-7375</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>October 3, 1910</b>                               |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  | 10a. State<br><b>Virginia</b>   |                                      | 10b. County<br><b>Fairfax</b>   |  | 10c. City, Town or Location<br><b>Alexandria</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                      | 10e. Street and Number<br><b>5904 Mount Eagle Drive Unit# 4810</b>  |  |   |  |
|   | 10f. Zip Code<br><b>22303</b>  |  |   |                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Civil Engineer</b>                |                                      | 16b. Kind of Business/Industry<br><b>City of New York</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Jasper T. Kane</b>   |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Laurette Riley</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathryn R. Kane</b>   |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5904 Mount Eagle Drive #4810 Alexandria, VA 22303</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Mary's Cemetery</b>  |                                      | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>  |  | 20d. Date<br><b>July 5, 1996</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |                                      | 22. Name and Address of Facility<br><b>Demaine Funeral Homes, Inc. Alexandria, Virginia 22314</b>   |  |   |  |
|   | 23a. Per 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>Chronic Subacute Pulmonary Dis &amp; Pneumonia</b><br>Due to (or as a consequence of):<br><b>Multiple cerebral infarctions</b><br>Due to (or as a consequence of):<br><b>Arteriosclerotic Cerebrovascular Dis.</b> |  |   |                                      |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |                                      |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |                                      |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |                                      |   |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Bilateral Deep Vein Thrombophlebitis</b><br><b>Arteriosclerotic Heart Disease</b><br><b>Gastrointestinal Bleeding</b>   |  |   |                                      |   |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                      | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |                                      | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  |   |                                      | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |                                      |   |  |   |  |
| 29b. Signature and title of certifier<br>   |  |  |   | 29c. License number<br><b>D07287</b> |   | 29d. Date signed (Month, Day, Year)<br><b>7-2-93</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RAM-CUNNINGHAM MD 11418 LIVINGSTON RD Fort Washington, MD 20744</b>  |  |  |   |                                      |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>   |  |  |   | 32. Registrar's Signature<br>        |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 21926

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |   |
|--|--|---|---|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Richard Warren Kurrus  |   |   |  | 2. Date of Death<br>Month Day Year<br>July 6, 1996   |   | 3. Time of Death<br>7:45 PM  |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br>10108 Counselman Road  |   |   |  | 4b. City, Town, or Location of Death<br>Potomac  |   | 4c. County of Death<br>Montgomery  |   |
| Funeral<br>Director  | 5. Social Security Number<br>011-20-9990   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>71 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Dec. 19, 1924  |  | 9. Birthplace (State or Foreign Country)<br>Massachusetts |
|  | Usual Residence of Decedent  |   |   |  |  |   |  |   |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |   | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Potomac   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br>10108 Counselman Road  |   |   |  | 10f. Zip Code<br>20854   |   | 10g. Citizen of What Country?<br>United States   |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Lawyer  |   | 16b. Kind of Business/Industry<br>Maritime Law   |   |
|  | 17. Father's Name (First, Middle, Last)<br>Warren E. Kurrus  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jennie Palm   |   |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Dorothy M. Kurrus/Wife   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10108 Counselman Road, Potomac, Maryland 20854  |   |  |   |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc.  |  | Date<br>July 9, 1996   |   | 20c. Location - City or Town, State<br>Bethesda, Maryland  |   |
|  | 21. Signature of Funeral Service Licensee<br><i>Randy Paul</i> M00198  |   | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>7557 Wisconsin Avenue<br>Bethesda, Maryland 20814-3501                              |  | Bethesda-Chevy Chase, Inc.   |   |  |   |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. Liver Failure<br>Due to (or as a consequence of):<br>b. Metastatic Cancer<br>Due to (or as a consequence of):<br>c. Cancer of Colon<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>1 month<br>1 1/2 years |   |   |  |  |   |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |  |   |
| 28d. Describe how injury occurred  |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |   |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |   |  |   |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |   |  |   |
| 29b. Signature and title of certifier<br><i>Stanley A. Schwartz</i> M.D.   |  |   |   | 29c. License number<br>D17368  |  | 29d. Date signed (Month, Day, Year)<br>July 8, 1996   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Stanley A. Schwartz, M.D. 5454 Wisconsin Ave., Chevy Chase, Maryland 20815   |  |   |   |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br>JUL 09 1996   |  |   |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>                             |  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified and all pages.

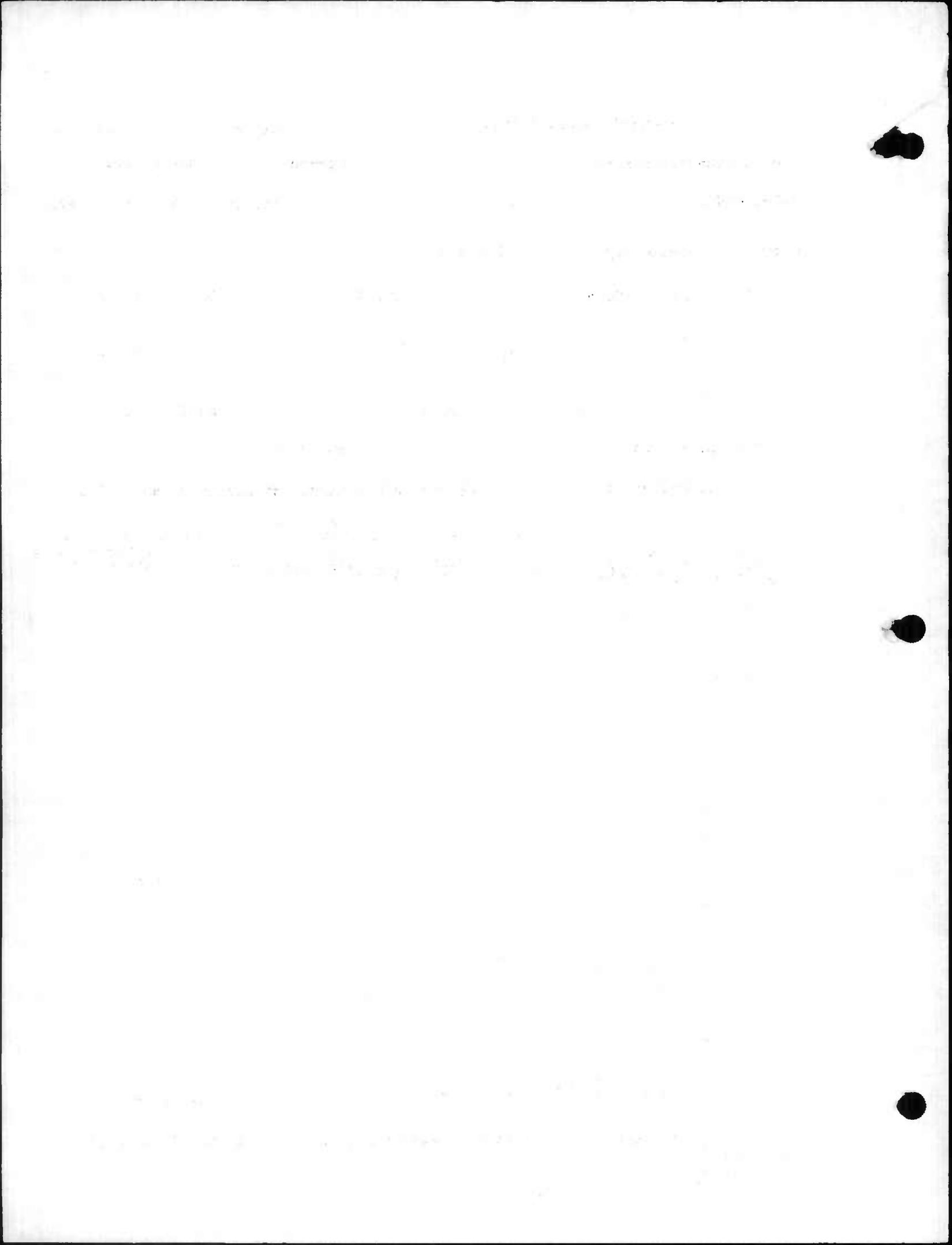
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21927

Certificate of Death

Reg. No.

|   |  |   |   |  |  |   |  |  |
|---|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Dolores Moxley Kopp  |   |   |  | 2. Date of Death<br>Month Day Year<br>July 10 1996   |   | 3. Time of Death<br>11:20 AM   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>731 West Bel Air Ave., Apt. 1D   |   |   |  | 4b. City, Town, or Location of Death<br>Aberdeen   |   | 4c. County of Death<br>Harford   |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-28-6578   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>64 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Dec. 30, 1931  |  | 9. Birthplace (State or Foreign Country)<br>North Carolina |
|   | Usual Residence of Decedent  |   |   |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Harford  |   | 10c. City, Town or Location<br>Aberdeen  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>731 West Bel Air Ave., Apt. 1D   |   |   |  | 10f. Zip Code<br>21001   |   | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                 |  |   | 16b. Kind of Business/Industry<br>Own Home   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charlie Clive Myers   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Blanche Wilma Jones   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Stephen J. Kopp - Husband  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>731 W. Bel Air Ave., Apt. 1D, Aberdeen, Md. 21001   |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gardens of Faith Cemetery 7-12-96   |  | 20c. Location - City or Town, State<br>Baltimore, Md.  |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br>Howard K. McComas III Funeral Home, P.A.<br>1317 Cokesbury Rd., Abingdon, Md. 21009  |   |  |  |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. Acute Coronary Artery Disease<br>Due to (or as a consequence of):<br>ASCVD<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>Osteoporosis<br><br>COPD   |   |   |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br>NA   |   | 28b. Time of Injury<br>NA M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred<br>NA                    |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>NA  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>NA              |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br> DME  |   | 29c. License number<br>OCME  |  | 29d. Date signed (Month, Day, Year)<br>July 10th 96   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>G.S. Prabhu M.D. 1810 Belair Rd. #102 Fallston MD. 21047, 410-879-6564  |  |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 11 1996  |  | 32. Registrar's Signature<br>  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

1912

1. The first part of the report is devoted to a general description of the work done during the year. It includes a summary of the results of the various experiments and a discussion of the methods used.

2. The second part of the report is devoted to a detailed description of the work done during the year. It includes a summary of the results of the various experiments and a discussion of the methods used.

3. The third part of the report is devoted to a detailed description of the work done during the year. It includes a summary of the results of the various experiments and a discussion of the methods used.

4. The fourth part of the report is devoted to a detailed description of the work done during the year. It includes a summary of the results of the various experiments and a discussion of the methods used.

5. The fifth part of the report is devoted to a detailed description of the work done during the year. It includes a summary of the results of the various experiments and a discussion of the methods used.

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |  |  |  |   |  |  |
|--|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>WALTER JOHN LUQUES</b>  |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>6</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>12:54 PM</b>                 |  |  |
| 4e. Facility Name (If not institution, give street and number)<br><b>CARROLL COUNTY GENERAL HOSPITAL</b>   |  |  | 4b. City, Town, or Location of Death<br><b>WESTMINSTER</b>   |  | 4c. County of Death<br><b>CARROLL</b>               |  |  |
| 5. Social Security Number<br><b>029-38-8613</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>11/25/1947</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>NEW JERSEY</b>  |  |  |  |  |   |  |  |
| Usual Residence of Decedent  |  |  |  |  |   |  |  |
| 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>CARROLL</b>  |  | 10c. City, Town or Location<br><b>WESTMINSTER</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>201 ST. MARK WAY</b>  |  |  | 10f. Zip Code<br><b>21158</b>  |  | 10g. Citizen of What Country?<br><b>USA.</b>        |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MANAGER</b>                      |  | 16b. Kind of Business/Industry<br><b>RESTAURANT</b> |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>STANLEY FALES LUQUES</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JUNE GERTRUDE SMITANSKY</b>  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JUNE G. LUQUES - MOTHER</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>201 St. MARK WAY, WESTMINSTER, MD. 21158</b> |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CARROLL CREMATION</b>   |  | Date<br><b>7/8/96</b>  |   | 20c. Location - City or Town, State<br><b>HAMPSTEAD, MD.</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME</b><br><b>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>                               |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Sudden cardiac death</b><br>Due to (or as a consequence of):<br><b>b. S/P MI 2/96</b><br>Due to (or as a consequence of):<br><b>c. S/P VT</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>5 months</b><br><b>5 months</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>7/6/96</b>  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  |  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>H39447</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>7-8-96</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr Scott Jerome 412 Malcolm Dr Westminister, Md</b>   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 8 1996</b>   |  | 32. Registrar's Signature<br>  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

x

x

5/2/20

1500

96 21929

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Myrtle I. Luistro</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH <i>July</i> DAY <i>08</i> YEAR <i>1996</i>  |  | 3. TIME OF DEATH<br><i>0820</i> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>321-30-4666</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>62</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>May 5, 1934</i>                                    |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><i>SHADY GROVE ADVENTIST HOSPITAL</i>  |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><i>ROCKVILLE</i>   |  | 8c. BIRTHPLACE (State or Foreign Country)<br><i>Ireland</i>                                     |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Montgomery</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Gaithersburg</i>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>18609 Walkers Choice Road, Apt. 2</i>   |  |   |  | 10f. ZIP CODE<br><i>20879</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Own Home</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>James Donaghy</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Margaret Devlin</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Phillip C. Mandalou</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2902 Randolph Road, Wheaton, Maryland 20902-1246</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>National Memorial Park July 12, 1996</i>  |  | 20c. LOCATION — City or Town, State<br><i>Falls Church, Virginia</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Barbara J. McMullan-Lawrence</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Robert A. Pumphrey Funeral Home/<br/>Rockville, Inc. 300 West Montgomery<br/>Avenue, Rockville, Maryland 20850-2805</i>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <i>Intraabdominal sepsis</i>   |  |   |  | Approximate Interval Between Onset and Death<br><i>1 week</i>                                   |  |
|  |  | b. <i>Colonic Perforation</i>   |  |   |  | <i>2 weeks</i>  |  |
|  |  | c. <i>Wegener's Granulomatosis</i>  |  |   |  | <i>10 months</i>  |  |
|  |  | d.  |  |   |  |   |  |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Obstructive Pulmonary Disease</i><br><i>Thrombocytopenia</i>  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Delecia MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D44503</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>July 09, 1996</i>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Emma Di Iorio 2730 University Boulevard West Wheaton MD</i>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>JUL 12 1996</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21930

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |  |  |  |
|--|---|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LEWIS A. LLOYD</b>                           |   |  |  | 2. Date of Death<br>Month <b>July</b> 5, Day <b>1996</b> Year |  | 3. Time of Death<br><b>4:05 p.m.</b>                       |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>4700 Accokeek Road</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Brandywine</b>     |  | 4c. County of Death<br><b>Prince Georges</b>               |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-14-4672</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.              |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 3, 1915</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Wash. DC</b>                                 |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince Georges</b>                          |  | 10c. City, Town or Location<br><b>Brandywine</b>           |  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>4700 Accokeek Road</b>   |  | 10f. Zip Code<br><b>20613</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>  |  | 16b. Kind of Business/Industry<br><b>Paving Co.</b>  |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward Lloyd</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lula West</b>  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary E. Lloyd (Wife)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4700 Accokeek Road, Brandywine, MD 20613</b>   |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 7/6</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>   |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>   |  |  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Carcinoma of the lung</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>1 yr.</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
|  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
|  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |  |  |
| 28f. Location (Street and Number or Rural/Route Number, City or Town, State)   |   |   |  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br> <b>MD</b>   |   |   |  | 29c. License number<br><b>D-16129</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>July 6, 1996</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William J. Oetgen, MD 9131 Piscataway Road #600 Clinton, MD 20735</b>   |   |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>  |   |   |  | 32. Registrar's Signature<br>   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

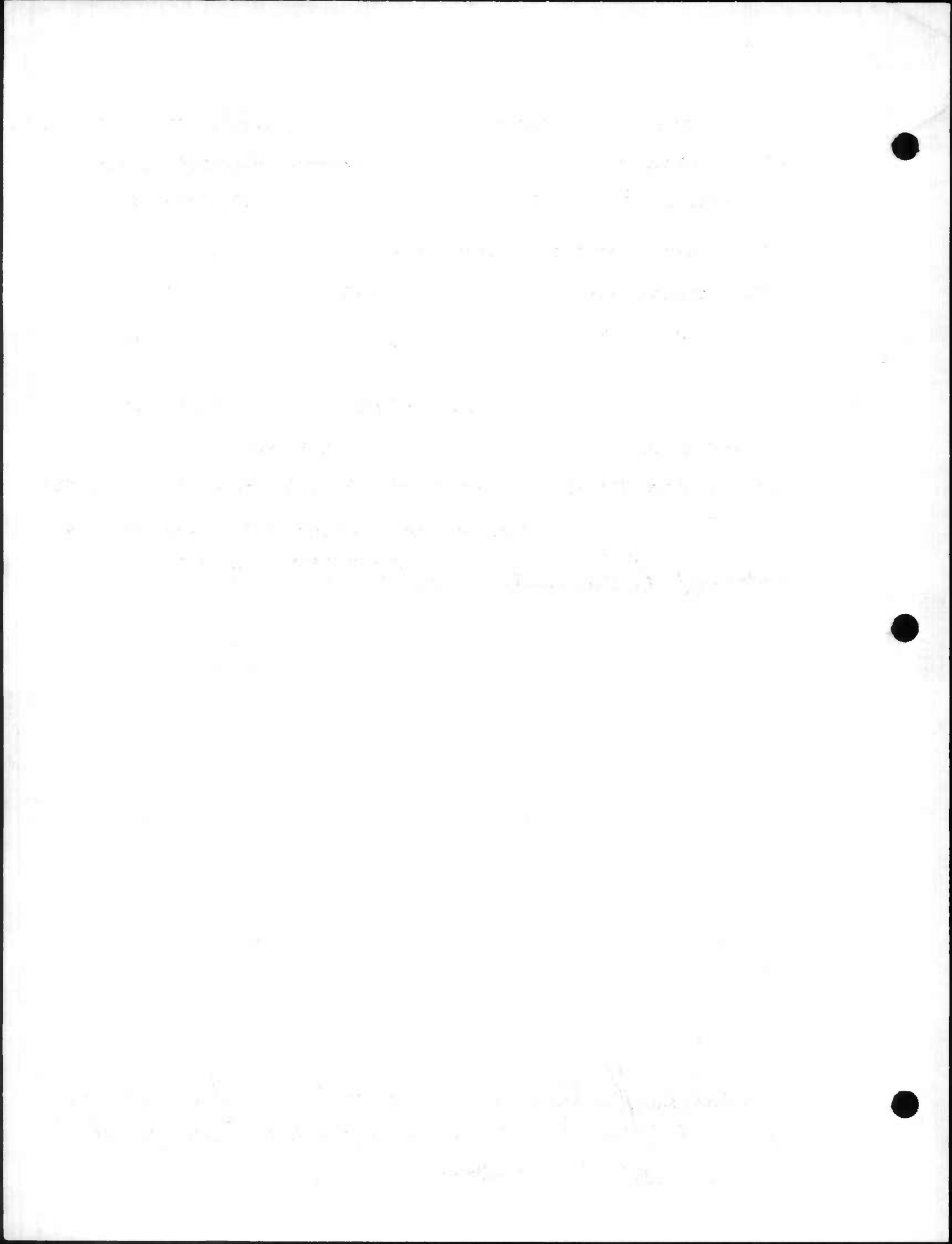
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21931

## Certificate of Death

Reg. No.

|  |   |  |  |  |   |   |  |  |
|--|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WILSON ADRIAN LANSFORD</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 7 1996</b>  |   | 3. Time of Death<br><b>3:59 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>   |   | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-12-6191</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>July 9, 1912</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Bethesda</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inade City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b><br>If Yes, Give Year or Dates: <b>Korea</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Claims Examiner</b>   |   | 16b. Kind of Business/Industry<br><b>United States Government</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Willis Raymond Lansford</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Louise Crockett</b>   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Christina L. Lansford/Daughter</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9743 52nd Avenue, College Park, Maryland 20740</b>                      |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Arlington, Virginia</b>   |   | 20d. Date<br><b>July 23, 1996</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><br><b>M00846</b>  |  | 22. Name and Address of Facility<br><b>Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>                     |  |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. SMALL CELL LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |   |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |   |   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |   |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |   |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><br><b>D. L. BLAZES, LT, MC, USNR</b>  |   |  |  | 29c. License number<br><b>RES-000</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>08 JUL 96</b>                                     |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>  |   |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>  |   |  |  | 32. Registrar's Signature<br> |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

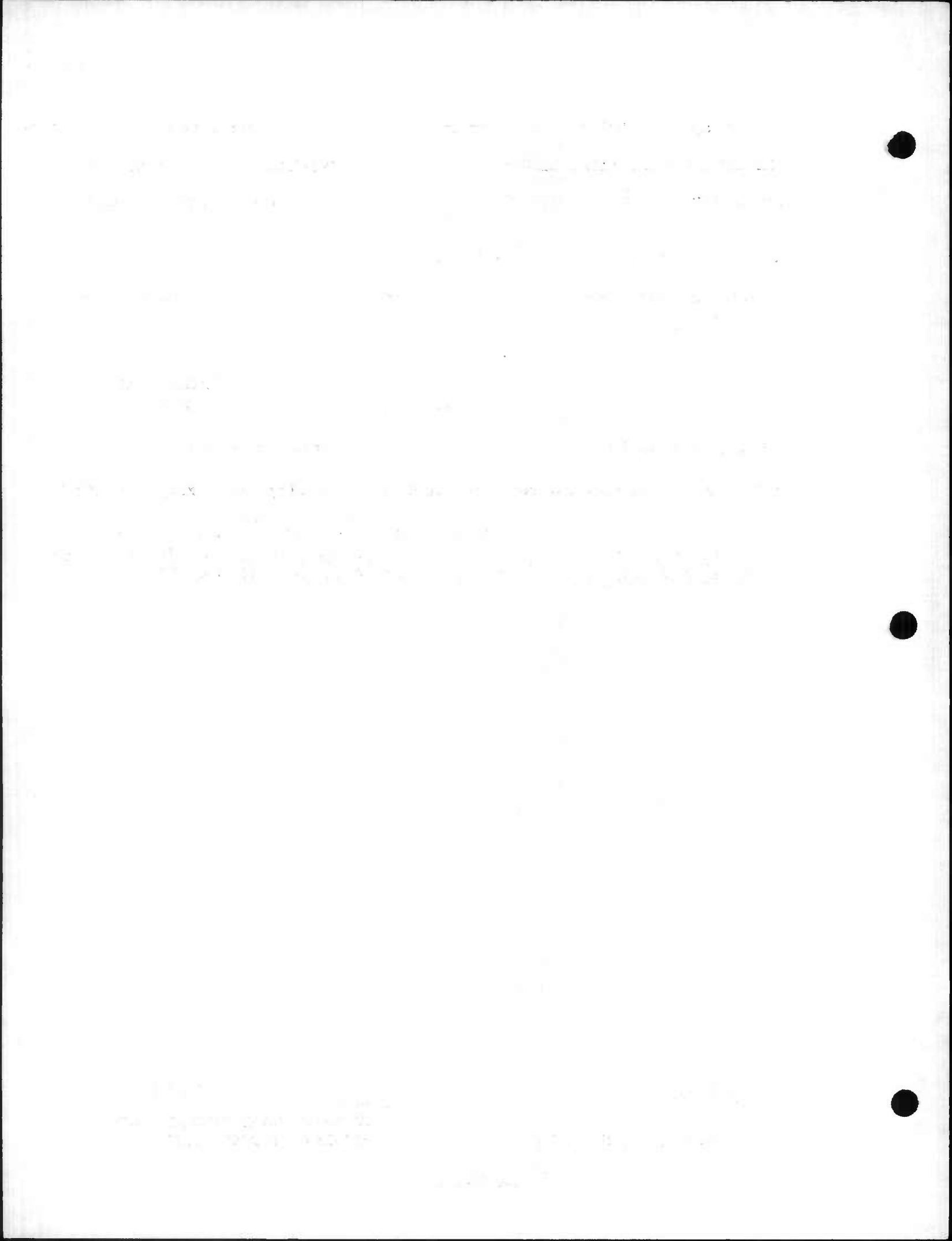
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



96 21932

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James Bernard Lowe   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 3, 1996   |  | 3. TIME OF DEATH<br>5:30PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>234-01-1260   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>87 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Nov. 28, 1908   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Circle Manor Nursing Home  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Kensington  |  |
| 9c. COUNTY OF DEATH<br>Montgomery  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  |
| 10c. CITY, TOWN OR LOCATION<br>Silver Spring   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>12317 Dewey Road   |  |
| 10f. ZIP CODE<br>20906   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Architect Representative   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>United States Government   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Fleming Lowe  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary E. Lowry   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Emilie V. Ernest   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12221 Eagles Nest Court, Unit F, Germantown, MD 20874   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc. July 5, 1996   |  | 20c. LOCATION — City or Town, State<br>Bethesda, Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Barbara Jo McMulley Lawrence</i> M00831  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert A. Humphrey Funeral Home/<br>Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>expiration pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><i>2 weeks</i> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Alzheimer's dementia</i>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Barbara Jo McMulley Lawrence, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br>D09834  |  | 29d. DATE SIGNED (Month, Day, Year)<br>7/3/96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>BARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD. 20891  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 09 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21933

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMONDE

2. Date of Death

Month Day Year  
JULY 4 1996

3. Time of Death

5:50AM

4a. Facility Name (If not institution, give street and number)

Mediplex of Gaithersburg

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

085-01-4045

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 2, 1900

9. Birthplace (State or Foreign Country)

France

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8717 Deanna Drive

10f. Zip Code

20882-1401

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Executive Secretary

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Louis Minois

18. Mother's Name (First, Middle, Maiden Summa)

Lucy Verliere

19a. Informant's Name/Relationship (Type, Print)

Violette Thouvenin/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8717 Deanna Drive, Gaithersburg, MD 20882-1401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
crematory, crematory or other place)

Montgomery Crematorium, Inc.

Date

July 5, 1996

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Raymond F...

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Cerebral Vascular Accident

Due to (or as a consequence of):

MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K...

29c. License number

D41866

29d. Date signed (Month, Day, Year)

JULY 4 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KANTAN HUDHUB, MD 481 N. FREDERICK AVE, 230 GAITHERSBURG, MD

31. Date filed (Month, Day, Year)

JUL 09 1996

32. Registrar's Signature

Julia...

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21934

Amended # 14, 7/11/96, MRT, Montgomery Cty. Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lora Ada Betty Lewis</b>   |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>4</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>7:05 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1400 Fenwick Lane, Apt #601</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>236-76-0987</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 18, 1937</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Piedmont, WV</b>   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>1400 Fenwick Lane, Apt. #601</b>   |   | 10f. Zip Code<br><b>20910</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Assistant</b>  |  | 16b. Kind of Business/Industry<br><b>Psychological Assoc.</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Horace Mann Lewis</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ada Betty Johnson</b>   |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lina Lewis Sturges</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4515 Clermont Place, P.O. Box 201, Garrett Park, MD 20896</b>   |  |  |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>7/6/96</b>  |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>John L. Chapak</i>  |   | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd.W. Silver Spring, MD 20901</b>   |  |  |  |  |  |
|   | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Constrictive Heart Failure</i><br>Due to (or as a consequence of):<br>b. <i>Arteriosclerotic Heart Disease</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |   | Approximate Interval Between Onset and Death<br><b>years</b><br><b>years</b>  |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |  |
|   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br><i>John L. Segal</i>   |  | 29c. License number<br><b>MD 10200</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/5/96</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jack P. Segal M.D. 5454 Wisconsin Avenue, Suite 925, Chevy Chase, MD 20815</b> |   | 31. Data filed (Month, Day, Year)<br><b>JUL 08 1996</b> |   |  |  |  |  |  |
| 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



## Reg. No.

**Medical Certification: To Be Completed by Physician/Medical Examiner**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21936

## Certificate of Death

Reg. No.

|  |   |  |   |   |  |  |   |  |  |   |  |
|--|---|--|---|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>TRENTA LIVERLY</u>   |  |   |   | 2. Date of Death<br>Month <u>JULY</u> Day <u>13</u> Year <u>1996</u>   |  |   |  | 3. Time of Death<br><u>8:39 a.m.</u>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>JOHNS HOPKINS HOSPITAL</u>   |  |   |   | 4b. City, Town, or Location of Death<br><u>BALTIMORE</u>   |  |   |  | 4c. County of Death<br><u>BALTIMORE</u>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>232-66-0838</u>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><u>53</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>May 10 1943</u> |  | 9. Birthplace (State or Foreign Country)<br><u>West Virginia</u>                                   |   |  |
|  | Usual Residence of Decedent   |  |   |   |  |  |   |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><u>MD</u>   |  | 10b. County<br><u>Cecil</u>   |   | 10c. City, Town or Location<br><u>Georgetown</u>   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><u>7070 Augustine Herman Hwy</u>  |  |   |   | 10f. Zip Code<br><u>21930</u>  |  |   |  | 10g. Citizen of What Country?<br><u>USA</u>  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:      |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                            |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Manager</u>  |  |   |  | 16b. Kind of Business/Industry<br><u>Food Service</u>  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><u>William Maynor</u>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Margie Bailey</u>  |  |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Vinson Lively</u>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7070 Augustine Herman Hwy Georgetown MD 21930</u>  |  |   |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Bethel Cemetery July 17 1996</u>   |   | Data<br><u>Chesapeake City MD</u>  |  | 20c. Location - City or Town, State                       |  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br><u>R. T. Foard Funeral Home P.A.<br/>318 George St. Chesapeake City MD 21915</u>   |  |   |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>MYOCARDIAL INFARCTION</u><br>Due to (or as a consequence of):<br>b. <u>MYOCARDIAL ISCHEMIA</u><br>Due to (or as a consequence of):<br>c. <u>GARDNER'S SHOCK</u><br>Due to (or as a consequence of):<br>d. <u>CHRONIC ATHERY DISEASE</u><br>Approximate Interval Between Onset and Death<br><u>6 HOURS</u><br><u>12 HOURS</u><br><u>12 HOURS</u><br><u>3 YEARS</u> |  |   |   |  |  |   |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |  |   |  |
|  |   |  |   | 24a. Was an autopsy performed?<br><u>Yes</u> 2 <input type="checkbox"/> No  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br><u>M</u>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   | 29b. Signature and title of certifier<br><u>RESIDENT M.D.</u>   |  |  |   | 29c. License number<br><u>N1281</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>JULY 13, 1996</u> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>RICHARD WALKER JOHNS HOPKINS HOSPITAL, BALTIMORE, MD 21287</u>  |   |  |   |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 15 1996</u>  |   |  |   | 32. Registrar's Signature<br>   |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

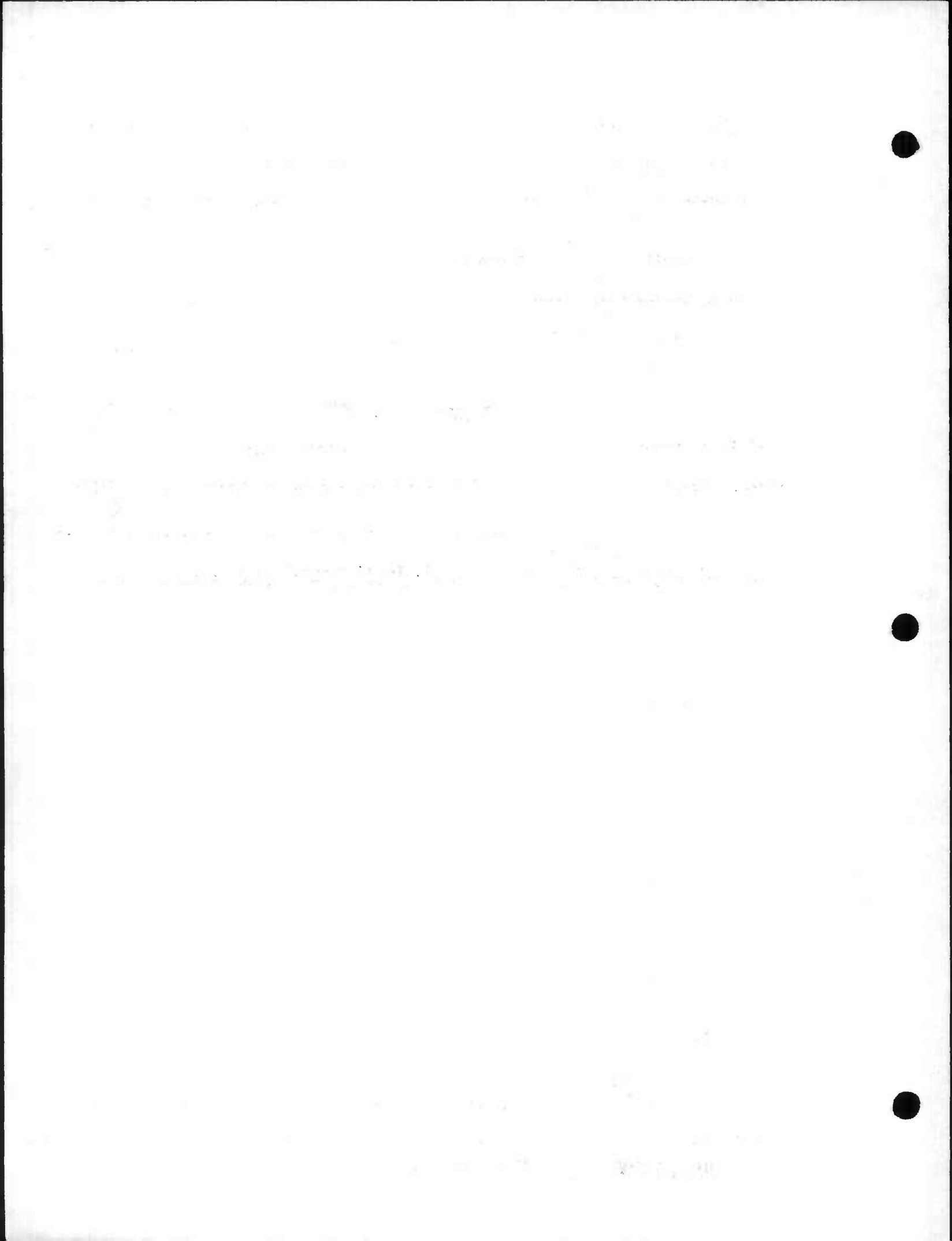
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



96 21937

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Gloria L. Marsh</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 8 1996</b>  |  | 3. TIME OF DEATH<br><b>8:44 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214 24 0743</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 28, 1927</b>                                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Alice Byrd Tawes Nursing Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Crisfield, MD</b>                                     |  |
| 9c. COUNTY OF DEATH<br><b>Somerset</b>   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Somerset</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Crisfield</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4 Wynfall Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21817</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 7</b><br>College (1-4 or 5+) <b>— — —</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Food Department</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Nursing Home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Merrill Tyler</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Myrtie Evans</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Christine V. Marshall (Daughter)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P. O. Box 26 - Ewell, MD 21824</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sunnyridge Memorial Park-7/11/96</b>   |  | DATE<br><b>7/11/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Crisfield, MD</b>                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert H. Bradshaw, Jr.</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bradshaw &amp; Sons Funeral Home<br/>306 W. Main St. - Crisfield, MD 21817</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypertensive Cardiovascular Disease</b> Approximate Interval Between Onset and Death <b>5 yrs</b>   |  |  |  |   |  |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Essential Hypertension, Severe</b> <b>10 yrs</b>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Multi. Infarct Dementia. NIDDM<br/>Depression; Multiple CVA<br/>Hypoalbuminemia of Chronic Disease</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kregg M. Bellon M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D29505</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7-9-96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, MD 21801</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 11 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Anderson</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text at the bottom of the page, possibly a signature or date.



96 21938

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RAYMOND ANDREW MCPHERSON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>07</b> DAY <b>10</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>4:30 P<sup>M</sup></b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>320-03-2044</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAR. 15, 1910</b>                          |   |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>WILLIAM HILL MANOR HEALTH CARE</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>EASTON</b>  |  | 9c. COUNTY OF DEATH<br><b>TALBOT</b>   |   |
| 10a. STATE<br><b>MARYLAND</b>   |  |  |  | 10b. COUNTY<br><b>TALBOAT</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>EASTON</b>   |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>501 DUTCHMAN'S LANE, APT. 202</b>  |  |  |  | 10f. ZIP CODE<br><b>21601</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>AUCTIONEER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>REAL ESTATE</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN WHALEY MCPHERSON</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LAVINIA MEYERS</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HELEN M. MCPHERSON</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>501 DUTCHMAN'S LANE, APT. 202, EASTON, MD</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATORY 7-12</b>  |  | 20c. LOCATION — City or Town, State<br><b>CHESTER, MD</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>B. Keith Phym, CFSP</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL<br/>200 S. HARRISON ST., EASTON, MD</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Cardiac Arrest</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Arteriosclerotic Heart Disease with the prior CHD</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>Seconds</b><br><b>Years</b>                            |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebral Arteriosclerosis</b><br><b>COPD</b>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William H. Wood Jr MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>008715</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/11/96</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>William H. Wood Jr 96 Idlewild Ave. EASTON MD 21601</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 12 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21939

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>William John McShea</b>                     |   | 2. Date of Death<br>Month <b>July</b> Day <b>2</b> Year <b>1996</b> |  | 3. Time of Death<br><b>0816</b>          |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Suburban Hospital</b> |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>             |  | 4c. County of Death<br><b>Montgomery</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>059-32-1170</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.                    | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.           |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 29, 1938</b>                                |   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>         |  |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Gaithersburg</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |
| 10e. Street and Number<br><b>19200 Dunbridge Way</b>  |  | 10f. Zip Code<br><b>20879</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1972</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>4</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Technician</b>   |   | 16b. Kind of Business/Industry<br><b>I.B.M.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank McShea</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cecilia McGarrin</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia M. McShea</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19200 Dunbridge Way, Gaithersburg, MD 20879</b>   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>7/5/96 Silver Spring, MD</b>   |  |
| 21. Signature of Funeral Service licensee<br>   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home<br/>10 East Deer Park Drive<br/>Gaithersburg, MD 20877</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Vasculitis</b><br><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>6yrs</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>6yrs</b>   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D47791</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>JULY 2, 1996</b>  |  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David A Holden MD 804 Veirs Mill Rd Rockville MD 20851</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>   |  | 32. Registrar's Signature<br>   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>FREDRICK MILTON MCCOY</b>  |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 07, 1996</b>   |  |  | 3. Time of Death<br><b>9:58 AM</b>       |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>9116 GLENRIDGE RD.</b>   |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b>   |  |  | 4c. County of Death<br><b>Montgomery</b> |  |  |
| 5. Social Security Number<br><b>215-48-9129</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.   |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 24, 1948</b> |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |  |  |  |  |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>9116 Glenridge Road</b>  |  |   |  | 10f. Zip Code<br><b>20910</b>  |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>4</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Programmer</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Computer</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Wilbur M. McCoy</b>   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bernys Ade</b>   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Wilbur M. McCoy</b>  |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>615 William Avenue, Miltonvale, Kansas 67466</b> |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>   |  | Date<br><b>7/12/96</b>   |  | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>                                  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  |  |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd. W. Silver Spring, MD 20901</b>                 |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>Subarachnoid Hemorrhage</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  |  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 08, 1996</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Marydon A. Konow an 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |  |  |

State  
Registrar

The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development.

The second part of the report deals with the economic situation. It is a very interesting and informative study of the country's economic development.

The third part of the report deals with the social situation. It is a very interesting and informative study of the country's social development.

The fourth part of the report deals with the political situation. It is a very interesting and informative study of the country's political development.

The fifth part of the report deals with the cultural situation. It is a very interesting and informative study of the country's cultural development.

The sixth part of the report deals with the environmental situation. It is a very interesting and informative study of the country's environmental development.

The seventh part of the report deals with the international situation. It is a very interesting and informative study of the country's international development.

The eighth part of the report deals with the future of the country. It is a very interesting and informative study of the country's future development.

The ninth part of the report deals with the conclusion. It is a very interesting and informative study of the country's conclusion.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21941

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |
|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>WENDY MARIE MILLER  |   |   | 2. Date of Death<br>Month Day Year<br>JUNE 30, 1996  |  | 3. Time of Death<br>03:30 PM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>DRIFTWOOD BEACH   |   |   | 4b. City, Town, or Location of Death<br>LUSBY  |  | 4c. County of Death<br>CALVERT   |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-21-9333  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>12 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>JULY 21, 1983   |
|  | 9. Birthplace (State or Foreign Country)<br>MARYLAND  |   |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND  |   | 10b. County<br>CALVERT  |  | 10c. City, Town or Location<br>LUSBY   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br>481 SADDLE COURT  |   |   | 10f. Zip Code<br>20657   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7th<br>College (1-4 or 5+) _____   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>STUDENT                                  |  | 16b. Kind of Business/Industry<br>MIDDLE SCHOOL  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>CLAUDE DAVID MILLER  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>DEBORAH ANN MILLER                                      |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>CLAUDE D. MILLER  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>SAME AS #10 |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>SOUTHERN MEM. GARDENS   |  | 20c. Location - City or Town, State<br>JULY 8, 1996 DUNKIRK, MD.   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Michael Brown</i>   |   | 22. Name and Address of Facility<br>RAYMOND FUNERAL HOME<br>DUNKIRK, MARYLAND 20754   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Multiple Injuries and Asphyxia<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE |   |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br>6-30-96   |   | 28b. Time of Injury<br>1500 M  |  | 28c. Injury of Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>SHORELINE OF BAY   |   | 28d. Describe how injury occurred<br>subject buried by fallen dirt and sand   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Driftwood Beach 20657        |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><i>James W. ...</i>   |   |   |   | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>JULY 01, 1996   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 10 1996   |   | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21942

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |   |  |  |
|---|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Marvin Everett Mundel</b>                     |   |  |  | 2. Date of Death<br>Month Day Year<br><b>July 9 1996</b>     |   | 3. Time of Death<br><b>6:40 A</b>                            |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b> |   | 4c. County of Death<br><b>Montgomery</b>                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>139-16-6094</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.             |   | 8. Date of Birth (Month, Day, Year)<br><b>April 20, 1916</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                  |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>                             |   | 10c. City, Town or Location<br><b>Silver Spring</b>          |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>821 Loxford Terrace</b>  |  | 10f. Zip Code<br><b>20901</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4or 5+) 5+</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Industrial/Engineer</b>   |  | 16b. Kind of Business/Industry<br><b>Consulting</b>  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Maxwell Mundel</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Aimee Baer</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Takako Mundel</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>821 Loxford Terrace, Silver Spring, MD 20901</b>   |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Date<br><b>7/12/96</b>  |  | 20d. Location - City or Town, State<br><b>Alexandria, Virginia</b>                          |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Robert E. Ramsey</b>  |  |   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd. W. Silver Spring, MD 20901</b>   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Congestive Heart FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |   |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Peter J. Sabia MD</b>   |  |   |  | 29c. License number<br><b>D40365</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 9, 1996</b>                                  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Peter J. Sabia, M.D. 10313 Georgia Ave Suite 308 Silver Spring, Md 20902</b>   |  |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 1996</b>   |  |   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21943

|  |   |   |   |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD ERNEST MOORE</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 05, 1996</b>   |  | 3. Time of Death<br><b>1555 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>18604 CROSS COUNTRY LANE</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>GAITHERSBURG</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>299-28-5615</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>6-8-1933</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Wisconsin</b>  |   | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Gaithersburg</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>18604 Cross Country Lane</b>   |  | 10f. Zip Code<br><b>20879-4603</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Patent Examiner</b>               |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Wilferd E. Moore</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clarinda Ripczinske</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Pastor Grant Layman / Clergy</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Covenant Life Church<br/>7501 Muncaster Mill Rd. Gaithersburg, Md. 20877</b>             |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Norbeck Memorial Gardens</b>   |  | 20c. Location - City or Town, State<br><b>7/10/96 Olney, Md.</b>   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Michael D. Gibbons</b>  |   |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home<br/>10 East Deer Park Dr. Gaithersburg, Md. 20877</b>  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pulmonary Thromboembolism Complicating</b><br>Died to (or as a consequence of):<br>b. <b>Ischemic Heart Disease</b><br>Died to (or as a consequence of):<br>c.<br>Died to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pericarditis</b>   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Theodore M. King</b>   |   |   |   | 29c. License number<br><b>O.C.M.E</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 06, 1996</b>                      |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 1996</b>  |   | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

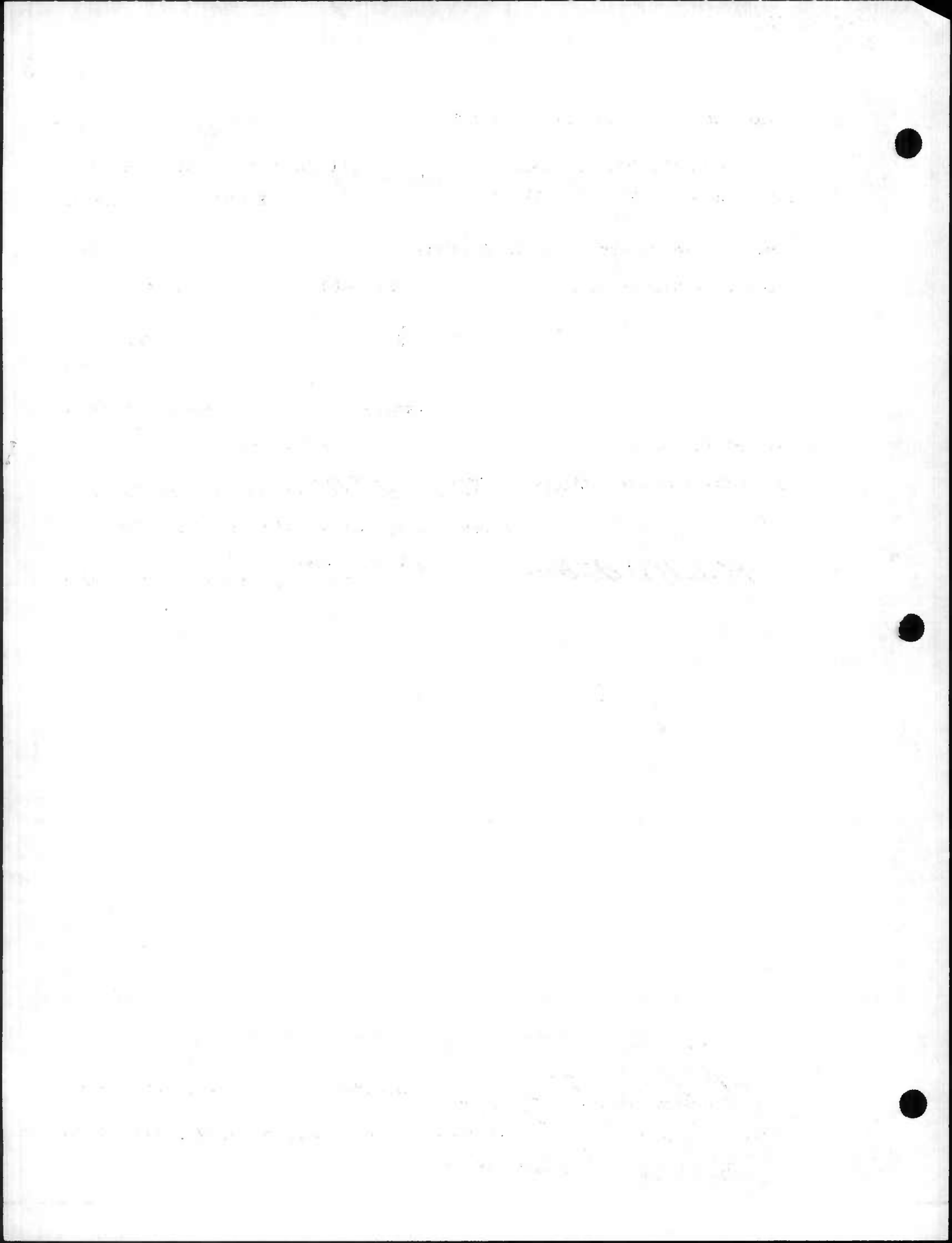
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21944

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |  |  |
|---|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Craig Huntington Melton</b>   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>3</b> Year <b>1996</b>  |  |   |  | 3. Time of Death<br><b>6:30 p.m.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>5011 Keokuk Street</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  |   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>224-15-6126</b>  |  | 6. Sex<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>34</b> Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  |
|   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan. 4, 1962</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Cheverly, MD</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Bethesda</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>5011 Keokuk Street</b>   |  | 10f. Zip Code<br><b>20816</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  |
|   | 11. Marital Status<br><b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                       |  |  |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Personnel Specialist</b>   |  | 16b. Kind of Business/Industry<br><b>U.S. Customs Service</b>  |  |   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Richard H. Melton</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Anderson</b>  |  |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard H. Melton - Father</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>715 S. Fairfax St., Alexandria, VA 22314</b>   |  |   |  |  |  |
|   | 20a. Method of Disposition<br><b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fairfax Memorial Park</b>  |  | Date<br><b>7/6/96</b>  |  | 20c. Location - City or Town, State<br><b>Fairfax, Virginia</b>   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><br><b>M00956</b>   |  | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons, Inc.</b><br><b>5130 Wisconsin Avenue, N.W.</b><br><b>Washington, D.C. 20016</b>  |  |  |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Cardiopulmonary Arrest</b><br>Due to (or as a consequence of):<br><br>b. <b>Brain Tumor (Glioblastoma, Multiforme)</b><br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____ |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input type="checkbox"/> Unknown |  |
|   |  |  |   |  |  |  |   |  | 24a. Was an autopsy performed?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No  |  |
|   |  |  |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
|   | 27. Manner of Death<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
|   | 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D41373</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 05, 1996</b>   |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Said Baidas, M.D. 3800 Reservoir Rd, N.W. Washington, D.C. 20007</b>  |  |   |  |  |  |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>  |  | 32. Registrar's Signature<br>  |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner




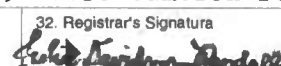
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

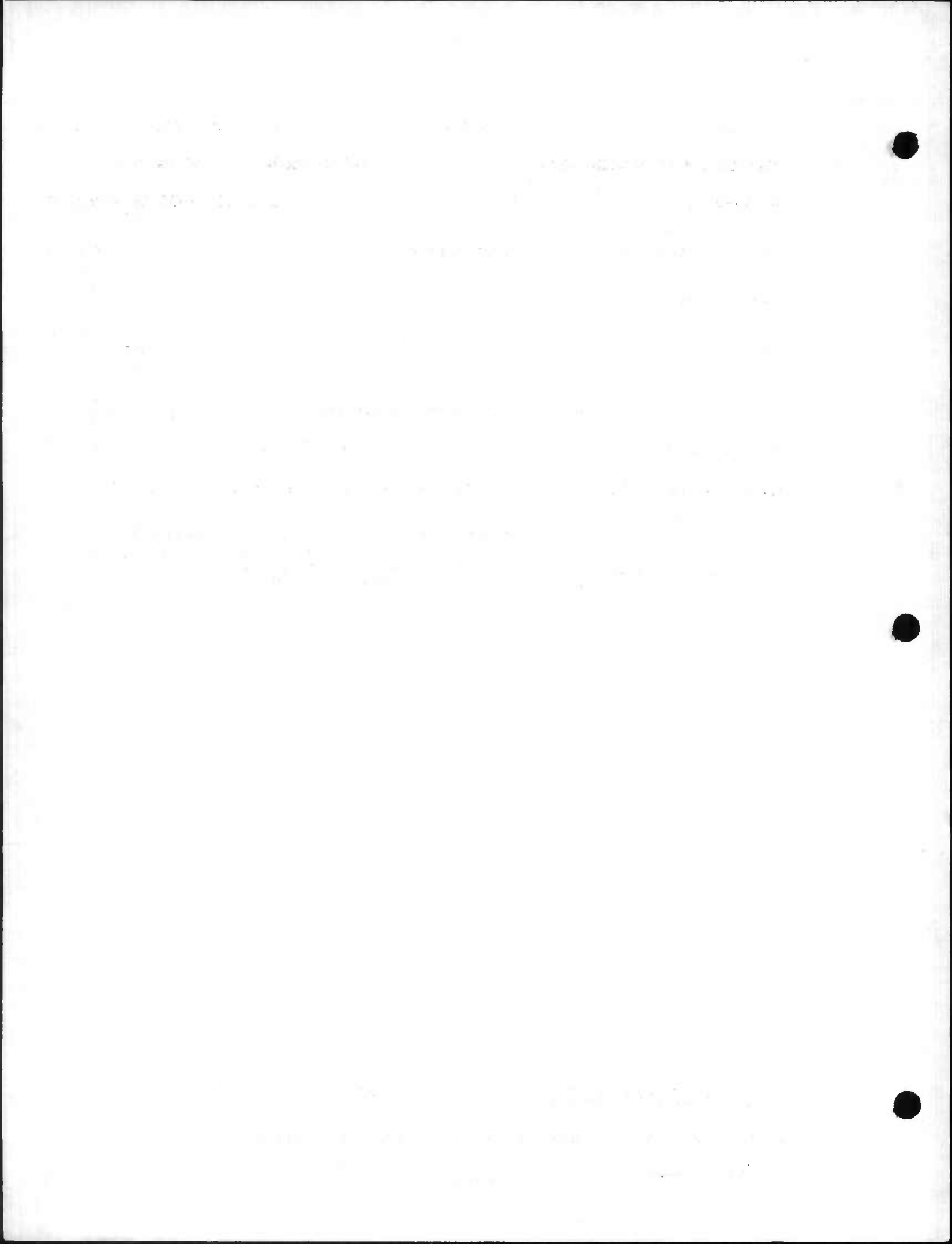
Reg. No.

96 21945

|  |   |   |   |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH M. MATHER</b>  |   |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>2</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>3:12 p.m.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>CARRIAGE HILL NURSING HOME</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>201-16-9786</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 13, 1905</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Scranton, PA</b>   |   | 10e. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>9101 2nd Avenue</b>   |  | 10f. Zip Code<br><b>20910</b>  |  |
|  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive Secretary</b>  |  | 16b. Kind of Business/Industry<br><b>Secretarial</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Wallace G. Moser</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Powell</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>William R. Wychulis</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6011 Exec. Blvd., #206, Rockville, MD 20852</b>  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hershey Cemetery</b>   |  | Data<br><b>7/8/96</b>  |  | 20c. Location - City or Town, State<br><b>Hershey, PA</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons, Inc.<br/>5130 Wisconsin Avenue, N.W.<br/>Washington, D.C. 20016</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Dementia</b><br>Due to (or as a consequence of):<br><br>b. <b>Sepsis</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>  |  |
|  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 43496</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 3, 1996</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mohammad A. Khalid, 8830 Cameron St., #502, Silver Spring, MD 20910</b> |   | 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b> |   | 32. Registrar's Signature<br> |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

96 21946

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES F. MACMULLAN</b>   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>5</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>2:45 pm</b>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-44-2342</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 10, 1910</b>                                 |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Sapulpa, OK</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Bethesda</b>  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
|   | 10e. Street and Number<br><b>5415 Lincoln Street</b>  |  |   |  | 10f. Zip Code<br><b>20817</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Attorney at Law</b>   |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                                    |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles Francis MacMullan</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Clarke</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn Miller MacMullan-Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5415 Lincoln Street, Bethesda, MD 20817</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |  | 20c. Date<br><b>7/10/96</b>   |  | 20d. Location - City or Town, State<br><b>Brentwood, Maryland</b>                           |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility Joseph Gawler's Sons, Inc.<br><b>5130 Wisconsin Avenue, N.W.<br/>Washington, D.C. 20016</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>sepsis</b><br>Dua to (or as a consequence of):<br><br>b. <b>gangrenous left leg</b><br>Dua to (or as a consequence of):<br><br>c. <b>vascular obstruction</b><br>Dua to (or as a consequence of):<br><br>d.<br>Dua to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.   | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>peripheral vascular disease</b>  |  |   |  |   |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |   |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. |   |  |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br>  |   |  |   | 29c. License number<br><b>D05581</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>7/5/96</b> |   |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>9410 G ED G E T O W N B E T H</b>  |   |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 08 1996</b>   |   |  |   | 32. Registrar's Signature<br> |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 21947

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>SYLVIA MARCUS</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 4, 1996</b>  |  | 3. Time of Death<br><b>11:30 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MONTGOMERY GENERAL HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>OLNEY</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>                                     |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>578-14-6332</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 11, 1918</b>                 |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, DC</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>MONTGOMERY</b>   |  | 10c. City, Town or Location<br><b>OLNEY</b>                                  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>18114 ROLLING MEADOW WAY</b>   |  | 10f. Zip Code<br><b>20832</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                        |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>      |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collegia (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>HYMAN STEIN</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>TILLIE HEIN</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>STEVEN MARCUS (SON)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13532 YOUNGWOOD TURN-BOWIE, MARYLAND 20715</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING DAVID</b>   |  | 20c. Location - City or Town, State<br><b>7-7-96 FALLS CHURCH, VIRGINIA</b>  |  | 20d. Date  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Robert J. [Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC.<br/>1170 ROCKVILLE, MARYLAND 20852</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>TERMINAL RENAL FAILURE WITH AZOTEMIA</b>   |  |   |  | Approximate Interval Between Onset and Death<br><b>2 WEEKS</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PROTRACTED HYPOTENSION &amp; PRE EXISTING RENAL FAILURE</b>   |  |   |  | Due to (or as a consequence of):<br><b>2 WEEKS</b>   |  |  |  |
|   | 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>RESECTION OF RUPTURED ABDOMINAL AORTIC ANEURYSM</b>   |  |   |  | Due to (or as a consequence of):<br><b>2 WEEKS</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CITRONIC OBSTRUCTIVE PULMONARY DISEASE</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
|   | 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE.</b>   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>REFLUX ESOPHAGITIS.</b>   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
|   | 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>REFLUX ESOPHAGITIS.</b>   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)                                       |  |
|   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br><b>MARIO H. DIAZ MD.</b>  |  | 29c. License number<br><b>D22049</b>   |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>7/4/96</b>   |  |   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARIO H. DIAZ MD. 18114 ROLLING MEADOW WAY OLNEY MD 20832</b>   |  | 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>                      |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><i>Julia Davidson [Signature]</i>   |  |   |  | 33. State Registrar<br><b>JUL 09 1996</b>  |  |  |  |
|   | 32. Registrar's Signature<br><i>Julia Davidson [Signature]</i>   |  |   |  | 33. State Registrar<br><b>JUL 09 1996</b>  |  |  |  |

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the data sources, the sampling procedure, and the statistical techniques employed.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings and their implications for the field of research.

4. The fourth part of the report is a conclusion and a discussion of the limitations of the study. It also includes a list of references and a list of appendices.

5. The fifth part of the report is a list of references and a list of appendices. The references are listed in alphabetical order, and the appendices are listed in numerical order.

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State of Maryland / Department of Health and Mental Hygiene

96 21948

## Certificate of Death

Reg. No.

|  |   |  |  |  |   |   |   |  |
|--|---|--|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Stehman S. Minnich                        |  |  |  | 2. Date of Death<br>Month Day Year<br>July 3 1996     |   | 3. Time of Death<br>10:15PM                         |  |
|  | 4e. Facility Name (If not Institution, give street and number)<br>Holy Cross Hospital |  |  |  | 4b. City, Town, or Location of Death<br>Silver Spring |   | 4c. County of Death<br>Montgomery                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>153-01-0766  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>101 Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br>Sept. 6 1894 |  |
|  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                              |  | 10a. State<br>Maryland   |  | 10b. County<br>Montgomery                             |   | 10c. City, Town or Location<br>Silver Spring        |  |
| Usual Residence of Decedent  |   |  |  |  |   |   |   |  |
| 10a. State<br>Maryland   |   |  | 10b. County<br>Montgomery  |  |   | 10c. City, Town or Location<br>Silver Spring  |   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  | 10e. Street and Number<br>3701 International Dr. Apt. #111   |  |   | 10f. Zip Code<br>20906  |   |  |
| 10g. Citizen of What Country?<br>United States   |   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4or 5+) 0                                |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales   |   |  | 16b. Kind of Business/Industry<br>Heating Equipment  |  |   | 17. Father's Name (First, Middle, Last)<br>John L. Minnich  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br>Barbara E. Stehman  |   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Leo Goulden / Friend   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15701 Ashland Drive Laurel, Maryland 20707           |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Moreland Park cemetery   |  |   | 20c. Location - City or Town, State<br>07/08/96 Baltimore, Md.  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Thomas Guyon</i>   |   |  | 22. Name and Address of Facility<br>Hines/Rinaldi Funeral Home<br>11800 New Hampshire Ave. Silver Spring, Md 20904   |  |   |   |   |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. SUBDURAL HEMATOMA Due to (or as a consequence of):<br>b. FALL DOWN STEPS Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br>5 WKS<br>5 WKS |   |  |  |  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |  |  |  |   |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |  |   |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |  |   |   |   |  |
| 26. Piece of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |   |  |  |  |   |   |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  |  |  |   |   |   |  |
| 28a. Date of Injury (Month, Day Year)<br>MAY 23 96   |   |  |  |  |   |   |   |  |
| 28b. Time of Injury<br>1400PM  |   |  |  |  |   |   |   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |   |   |   |  |
| 28d. Describe how Injury occurred<br>FELL DOWN STEPS   |   |  |  |  |   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>BEDFORD COURT  |   |  |  |  |   |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>LEISURE WORLD  |   |  |  |  |   |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |  |   |   |   |  |
| 29b. Signature and title of certifier<br><i>Frank C. Mayle</i>   |   |  |  |  |   |   |   |  |
| 29c. License number<br>D07099  |   |  |  |  |   |   |   |  |
| 29d. Date signed (Month, Day, Year)<br>JULY 6 96   |   |  |  |  |   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>FRANK C MAYLE 1025 FERNWOOD RD BETHESDA MD 20817   |   |  |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 09 1996   |   |  |  |  |   |   |   |  |
| 32. Registrar's Signature<br><i>John Davidson-Randall</i>  |   |  |  |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21949

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
|--|---|---|---|--|--|--|--|---|---|-----------------------------------|--|-------------------------------------|-------------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CARRIE Mc GLOTHLIN</b>   |   |   |  | 2. Date of Death<br>Month <b>07</b> Day <b>08</b> Year <b>96</b>   |  | 3. Time of Death<br><b>1500</b>  |   |   |                                   |  |                                     |                                     |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MEDPOINTE CONTINUING CARE FACILITY</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>ELKTON</b>  |  | 4c. County of Death<br><b>CECIL</b>  |   |   |                                   |  |                                     |                                     |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-22-5059</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan. 10, 1908</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |   |                                   |  |                                     |                                     |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |                                   |  |                                     |                                     |
|  | 10e. Street and Number<br><b>6727 Mallard Road</b>  |   |   |  | 10f. Zip Code<br><b>21220</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |                                   |  |                                     |                                     |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |   |                                   |  |                                     |                                     |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>  |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |  | 16b. Kind of Business/Industry<br><b>In home</b>   |  |   |   |                                   |  |                                     |                                     |
|  | 17. Father's Name (First, Middle, Last)<br><b>unk Ferren</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anne Davis</b>   |  |  |   |   |                                   |  |                                     |                                     |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kenny McGlothlin (son)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1610 Shirley Ave., Joppa, MD 21085</b>   |  |  |   |   |                                   |  |                                     |                                     |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harford Memorial Gardens</b>   |  | Date<br><b>7/11/96</b>   |  | 20c. Location - City or Town, State<br><b>Aberdeen, Maryland</b>                               |   |   |                                   |  |                                     |                                     |
|  | 21. Signature of Funeral Service Licensee<br><b>Kenneth B. Cayer</b>  |   |   |  | 22. Name and Address of Facility<br><b>Tarring-Cargo Funeral Home, P.A.<br/>Aberdeen, Maryland 21001-3399</b>  |  |  |   |   |                                   |  |                                     |                                     |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Coronary artery disease</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>3 years</b></td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> |   |   |  |  |  |  |   | Immediate Cause (Final disease or condition resulting in death) | a. <b>Coronary artery disease</b> | Approximate Interval Between Onset and Death<br><b>3 years</b> | b. Due to (or as a consequence of): | c. Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)  | a. <b>Coronary artery disease</b>   | Approximate Interval Between Onset and Death<br><b>3 years</b>  |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
|  | b. Due to (or as a consequence of):   |   |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
|  | c. Due to (or as a consequence of):   |   |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
|  | d. Due to (or as a consequence of):   |   |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's</b><br><b>Emphysema</b>   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |   |                                   |  |                                     |                                     |
|  |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |                                   |  |                                     |                                     |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |                                   |  |                                     |                                     |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |                                   |  |                                     |                                     |
| 28d. Describe how injury occurred  |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |   |   |                                   |  |                                     |                                     |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |   |   |   | 29c. License number<br><b>028339</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 9, 1996</b>   |  |   |   |                                   |  |                                     |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LINDA FREUCH 101 E Wheel Road Bel Air, Maryland</b>   |   |   |   |  |  |  |  |   |   |                                   |  |                                     |                                     |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |  |  |   |   |                                   |  |                                     |                                     |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21950

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA LAVIN MARGOLIS

2. Date of Death

Month Day Year  
July 12, 1996

3. Time of Death

8:00 PM

4a. Facility Name (If not institution, give street and number)

Waldorf Health Care Center

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

189-05-1658

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 4, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1806 Alberti Drive

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

18e. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Martin Francis Lavin

18. Mother's Name (First, Middle, Maiden Surname)

Anna Lavin

19a. Informant's Name/Relationship (Type, Print)

Martin Margolis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7422 Shirley Blvd., Port Tobacco, MD 20617

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Data

20c. Location - City or Town, State

Hanover Township, PA

21. Signature of Funeral Service Licensee

Benjamin Matthews M00658

22. Name and Address of Facility

Huntt Funeral Home, Inc.  
P. O. Box 156, Waldorf, MD 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *liver carcinoma*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&gt;5yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charlene A. Letchford

29c. License number

D46419

29d. Date signed (Month, Day, Year)

7/13/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlene A. Letchford, 700 Old Line Center #100, Waldorf, MD 20602

31. Date filed (Month, Day, Year)

JUL 15 1996

32. Registrar's Signature

Julia Anderson-Rodall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed in full in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21951

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |   |   |  |  |  |
|---|---|--|---|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT EDWARD MITZEL</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 11 1996</b>  |   | 3. Time of Death<br><b>9:30 AM</b>  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1183 PLEASANT VALLEY ROAD</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>WESTMINSTER</b>   |   | 4c. County of Death<br><b>CARROLL</b>   |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-42-0209</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>10/14/1943</b>                                    |  |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>CARROLL</b>  |   | 10c. City, Town or Location<br><b>WESTMINSTER</b>   |  |  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1183 PLEASANT VALLEY RD.</b>   |  | 10f. Zip Code<br><b>21158</b>  |   | 10g. Citizen of What Country?<br><b>USA.</b>  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ELECTRICIAN</b>                   |  | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>  |   |   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>LEVERE ALLEN MITZEL</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CHRISTINE ROSSER</b>   |   |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>VICKI NOVAK - DAUGHTER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 336, UNION BRIDGE, MD. 21791</b>  |   |   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CARROLL CREMATION</b>  |  | 20c. Location - City or Town, State<br><b>7/12/96 HAMPSTEAD, MD.</b>   |   |   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME<br/>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>                                      |  |  |   |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immadiata Causa (Final disease or condition resulting in death)<br>a. <b>shotgun wound of Head</b><br>Dua to (or as a consequence of):<br>b.<br>Dua to (or as a consequence of):<br>c.<br>Dua to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |   |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |   |   |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |   |   |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |   |  |  |   |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |   |   |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |  |   |   |  |  |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicida <input type="checkbox"/> Homicida<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>7-11-96</b>  |  | 28b. Time of Injury<br><b>0910 M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred<br><b>subject shot self.</b> |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Residence</b>  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1183 Pleasant Valley Rd</b>   |   |   |  |  |  |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated.   |   |  |   |  |  |   |   |  |  |  |
| 29b. Signature and title of Certifier<br>   |   |  |   | 29c. License number<br><b>O.C.M.E.</b> |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 11, 1996</b> |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David R Fowler. 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |   |  |  |   |   |  |  |  |
| 31. Data filed (Month, Day, Year)<br><b>JUL 15 1996</b>   |   |  |   | 32. Registrar's Signature<br>          |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21952

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Howard Mangold</b>   |  |   |  | 2. Date of Death<br>Month <b>7</b> Day <b>10</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>5:30 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Residence: 63 Kanawha Drive</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Rising Sun</b>   |  | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>222-22-1669</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 13, 1937</b>                  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Rising Sun</b>                             |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>63 Kanawha Drive</b>   |  | 10f. Zip Code<br><b>21911</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                               |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1961-63</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>      |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) _____ College (1-4 or 5+) <b>Two Years</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Training Coordinator</b>  |  | 16b. Kind of Business/Industry<br><b>Sun Oil Company</b>  |  | 16c. Location - City or Town, State<br><b>Marcus Hook, Pennsylvania</b>      |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Peter Albert Mangold</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ellen Kirk Larkin</b>   |  |  |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia A. Mangold (wife)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>63 Kanawha Drive, Rising Sun, Maryland 21911</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Darlington Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>7/14/96 Darlington, Maryland</b>  |  | 20d. Date  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Thomas M. Patterson, Sr.</b>   |  |   |  | 22. Name and Address of Facility<br><b>Lee A. Patterson &amp; Son Funeral Home<br/>Perryville, Maryland 21903</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Adenocarcinoma of the esophagus</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate interval Between Onset and Death  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Metastasis to meninges (brain)</b><br><b>Upper cervical spine</b>   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)                                       |  |
|   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br><b>D. L. Pirovolidis MD</b>  |  | 29c. License number<br><b>DO 9574</b>  |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>7/10/96</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>D. L. Pirovolidis 104 Plumtree Rd Belair, Md. 21014</b>  |  | 31. Date filed (Month, Day, Year)<br><b>7 JUL 18 1996</b>   |  | 32. Registrar's Signature<br><b>J. L. Davidson-Randall</b>                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

96 21953

## Certificate of Death

Reg. No.

|   |  |  |   |                                       |  |  |   |   |  |  |
|---|--|--|---|---------------------------------------|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John D. Morris</b>  |  |   |                                       |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>10</b> Year <b>1996</b>  |   | 3. Time of Death<br><b>02100</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Union Hospital</b>  |  |   |                                       |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>   |   | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>277-14-2420</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 31 1920</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>  |  |
|   | Usual Residence of Decedent  |  |   |                                       |  |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Cecil</b>   |                                       | 10c. City, Town or Location<br><b>Chesapeake City</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>128 Hollywood Beach Rd.</b>   |  |   |                                       | 10f. Zip Code<br><b>21915</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | College (1-4or 5+)  |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>   |  |   | 16b. Kind of Business/Industry<br><b>Industry</b>                       |  |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>James A. Morris</b>  |  |   |                                       |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Evans</b>   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charlene Smith</b>  |  |   |                                       |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>128 Hollywood Beach Rd Chesapeake City MD 21915</b> |   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                        |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R A Ferris</b>   |                                       | Date<br><b>July 12, 1996</b>   |  | 20c. Location - City or Town, State<br><b>West Chester PA</b>   |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Robert J. Foad</b>   |  | 22. Name and Address of Facility<br><b>R. T. Foad Funeral Home, PA<br/>318 George St. Chesapeake City MD 21915</b>  |                                       |  |  | Approximate Interval Between Onset and Death  |   |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |                                       |  |  |   |   |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>END STAGE COPD</b><br>Due to (or as a consequence of):<br><b>Respiratory Failure</b>   |  |   |                                       |  |  |   |   |  |  |
|   | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):   |  |   |                                       |  |  |   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                       |  |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |                                       |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                       |  |  |   |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                       |  |  |   |   |  |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |                                       | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |                                       |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |                                       |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |  |   | 29c. License number<br><b>D 32395</b> |  |  | 29d. Date signed (Month, Day, Year)<br><b>7-12-96</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas Finucan, 3 MAULDTN AVE, NORTH EAST MD 21901</b>   |  |  |   |                                       |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>                              |   |                                       |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.

3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, a comparison of the results with previous research, and a conclusion about the significance of the study.

4. The fourth part of the report is a discussion of the implications of the study. It includes a discussion of the limitations of the study, the strengths of the findings, and the potential for future research.

5. The fifth part of the report is a summary of the study. It includes a brief overview of the main findings and a final conclusion about the importance of the research.



96 21954

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Eleanor Teresa McKay   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 12, 1996  |  | 3. TIME OF DEATH<br>5:55 P. M  |  |
| 4. SOCIAL SECURITY NUMBER<br>216-42-6373   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>69 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 13, 1927  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Connecticut  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Route 5 Box 382D   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Lexington Park  |  |
| 9c. COUNTY OF DEATH<br>St. Mary's  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>St. Mary's  |  |
| 10c. CITY, TOWN OR LOCATION<br>Lexington Park  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>Route 5, Box 382D  |  |
| 10f. ZIP CODE<br>20653   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5 College (1-4 or 5+) 5  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>N/A  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Salvatore Perrera   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Concetta DeMattea   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Eleanor T. Pulliam   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Route 5 Box 382C, Lexington Park, Maryland 20653  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Charles Memorial Gardens 7-16-96  |  | 20c. LOCATION — City or Town, State<br>Leonardtwn, Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE AGENT<br><i>Edward N. Brinsfield, Jr.</i> M00052  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Brinsfield Funeral Home, P.A.<br>P.O. Box 279, Leonardtown, Maryland 20650   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>prob metastatic bladder carcinoma</i> 3 Years   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>COPD / HTN / Arthritis</i>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>K. Keat MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D36206</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>07/11/96</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Kiron D. Mehta MD Leonardtown MD 20650</i>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>JUL 16 1996</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 21955

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ralph Myhand</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>5</b> YEAR <b>96</b>  |  | 3. TIME OF DEATH<br><b>12:30 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>423-26-8947</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-15-1925</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Ala.</b>   |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>Waterview Rehab Center</b>  |  | 10. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>  |  |
| 11. COUNTY OF DEATH<br><b>Wicomico</b>  |  |  |  | 12. RESIDENCE OF DECEDENT<br>10a. STATE <b>MD</b> 10b. COUNTY <b>SOMERSET</b> 10c. CITY, TOWN OR LOCATION <b>MARION</b>   |  | 13. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 14. STREET AND NUMBER<br><b>5025 WAYMAN RD.</b>   |  |  |  | 15. ZIP CODE<br><b>21838</b>  |  | 16. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 17. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 20. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 21. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>10</b>  |  | 22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>  |  | 23. KIND OF BUSINESS/INDUSTRY<br><b>RAILROAD</b>  |  |  |  |
| 24. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>   |  |  |  | 25. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CLARA P. Hs</b>   |  |  |  |
| 26. INFORMANT'S NAME (Type/Print)<br><b>Willie Schoolfield</b>  |  |  |  | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 732 Princess Anne Md. 21853</b>   |  |  |  |
| 28. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>John Wesley Cottage Groves WESTOVER Md.</b>   |  | 30. LOCATION — City or Town, State<br><b>Princess Anne Md. 21853</b>  |  |  |  |
| 31. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Anthony S. Ward</b>   |  |  |  | 32. NAME AND ADDRESS OF FACILITY<br><b>30639 Hampden Ave. Princess Anne Md. 21853</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Empty space</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary heart disease</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>Arteriosclerosis</b> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 24. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |  |  |
| 26. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 27. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 28. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 29. DATE OF INJURY (Month, Day, Year)  |  | 30. TIME OF INJURY<br><b>M</b>  |  | 31. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 32. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 33. DESCRIBE NOW INJURY OCCURRED  |  |  |  |
| 34. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 35. DATE OF INJURY  |  |  |  |
| 36. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 37. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |  |  | 38. LICENSE NUMBER<br><b>229349</b>   |  | 39. DATE SIGNED (Month, Day, Year)<br><b>7/8/96</b>  |  |
| 40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Waterview Rehabilitation Center Salisbury Md. 21801</b>   |  |  |  |   |  |  |  |
| 41. DATE FILED (Month, Day, Year)<br><b>JUL 11 1996</b>   |  |  |  | 42. REGISTRAR'S SIGNATURE<br><b>John Anderson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21956

|   |  |   |  |   |  |   |  |  |
|---|--|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LAURA CALE NERENBERG</b>                            |   |  |   | 2. Date of Death<br>Month Day Year<br><b>JULY 8, 1996</b>    |   | 3. Time of Death<br><b>5:08 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>15027 SHAMROCK RIDGE ROAD</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b> |   | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>198-40-2837</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                               |   | 7. Age (In yrs. last birthday)<br><b>31</b> Yrs.             |   | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 8, 1964</b>                                     |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, D.C.</b>                                |   |  |   |  |   |  |  |
| Usual Residence of Decedent   |  |   |  |   |  |   |  |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>SILVER SPRING</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>15027 SHAMROCK RIDGE ROAD</b>  |  |   |  | 10f. Zip Code<br><b>20906</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                                       |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>RECREATIONAL THERAPIST</b>  |  |   | 16b. Kind of Business/Industry<br><b>ADOLESCENT TREATMENT CENTER</b>                           |  |
| 17. Father's Name (First, Middle, Last)<br><b>ROY NERENBERG</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CAROL KOHN</b>  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROY NERENBERG (FATHER)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10104 LOGAN DRIVE - POTOMAC, MARYLAND 20854</b>   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JUDEAN MEMORIAL GARDENS</b> |   | Date<br><b>7/10/96</b>                                       |   | 20c. Location - City or Town, State<br><b>OLNEY, MARYLAND</b>                                  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852</b>  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>CARDIAC ARREST</b><br>Due to (or as a consequence of):<br><br>b. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |   |  | Approximate interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |  |   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>019301</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 9, 1996</b>                                  |  |  |
| 30. Name and address of person who completed cause of death (Form 23a) (Type, Print)<br><b>ROBERT A. VIGERSKY, MD - 5530 WISCONSIN AVENUE #527 - CHEVY CHASE, MARYLAND 20815</b>  |  |   |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>   |  |   |  | 32. Registrar's Signature<br>   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance in the theory of the structure of the atom.

2. In the second part of the paper, the author gives a detailed account of the experimental results obtained by him and his co-workers. It is shown that the results are in good agreement with the theoretical predictions.

3. The third part of the paper is devoted to a discussion of the results of the experiment. It is shown that the results are in good agreement with the theoretical predictions.

4. In the fourth part of the paper, the author gives a detailed account of the experimental results obtained by him and his co-workers. It is shown that the results are in good agreement with the theoretical predictions.

5. The fifth part of the paper is devoted to a discussion of the results of the experiment. It is shown that the results are in good agreement with the theoretical predictions.

6. In the sixth part of the paper, the author gives a detailed account of the experimental results obtained by him and his co-workers. It is shown that the results are in good agreement with the theoretical predictions.

7. The seventh part of the paper is devoted to a discussion of the results of the experiment. It is shown that the results are in good agreement with the theoretical predictions.

8. In the eighth part of the paper, the author gives a detailed account of the experimental results obtained by him and his co-workers. It is shown that the results are in good agreement with the theoretical predictions.

9. The ninth part of the paper is devoted to a discussion of the results of the experiment. It is shown that the results are in good agreement with the theoretical predictions.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21957

|   |   |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|---|---|---|---|--|--|--|--|--|---|--------------|--------|----------------------------------|--|-----------|--------|----------------------------------|--|--|----------------------------|---------|----------------------------------|--|----------------------|----------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Lucille Cook Nickerson  |   |   |  | 2. Date of Death<br>Month Day Year<br>July 10, 1996  |  | 3. Time of Death<br>9:47 PM                                      |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | 4a. Facility Name (If not institution, give street and number)<br>Manor Care-Bethesda   |   |   |  | 4b. City, Town, or Location of Death<br>Chevy Chase  |  | 4c. County of Death<br>Montgomery                                |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| Funeral<br>Director   | 5. Social Security Number<br>032-10-0136  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>80 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 13, 1916             |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | 9. Birthplace (State or Foreign Country)<br>Massachusetts   |   | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery  |  | 10c. City, Town or Location<br>Kensington                        |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br>10003 Wildwood Court  |  | 10f. Zip Code<br>20895   |  | 10g. Citizen of What Country?<br>United States                   |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                |  | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | 17. Father's Name (First, Middle, Last)<br>Leon W. Cook   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nellie P. Rich  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Gail N. Smith / daughter  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10003 Wildwood Court, Kensington, Maryland 20895  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc.  |  | Date<br>July 12, 1996  |  | 20c. Location - City or Town, State<br>Bethesda, Maryland        |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>Rockville, Inc. 300 West Montgomery<br>Avenue, Rockville, Maryland 20850-2805 |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Pneumonia</td> <td>3 days</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. Stroke</td> <td>1 year</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. Cerebrovascular Disease</td> <td>4 years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d. Diabetes mellitus</td> <td>15 years</td> </tr> </table> |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. Pneumonia | 3 days | Due to (or as a consequence of): |  | b. Stroke | 1 year | Due to (or as a consequence of): |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Cerebrovascular Disease | 4 years | Due to (or as a consequence of): |  | d. Diabetes mellitus | 15 years |
|   | Immediate Cause (Final disease or condition resulting in death)   | a. Pneumonia  | 3 days  |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| Due to (or as a consequence of):  |   |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| b. Stroke   |   | 1 year  |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| Due to (or as a consequence of):  |   |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | c. Cerebrovascular Disease  | 4 years   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   | Due to (or as a consequence of):  |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| d. Diabetes mellitus  | 15 years  |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Arteriosclerotic Heart Disease  |   |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of injury (Month, Day Year)   |   | 28b. Time of injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
|   |   | 28d. Describe how injury occurred   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br>D30844  |  | 29d. Date signed (Month, Day, Year)<br>July 11, 1996                                 |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>James F. McMurry, Jr., M.D. 6318 Democracy Boulevard, Bethesda, Maryland 20817-1631   |   |   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |
| 31. Date filed (Month, Day, Year)<br>JUL 12 1996  |   | 32. Registrar's Signature<br>   |   |  |  |  |  |  |   |              |        |                                  |  |           |        |                                  |  |  |                            |         |                                  |  |                      |          |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

11. 12. 13. 14. 15. 16. 17. 18. 19. 20.

21. 22. 23. 24. 25. 26. 27. 28. 29. 30.

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151. 152. 153. 154. 155. 156. 157. 158. 159. 160.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21958

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b allow any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |   |  |                                |  |  |  |   |
|--|--|--|---|--|--------------------------------|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br>Evelyn K. Nickels  |  |  |   |  |                                | 2. Date of Death<br>Month Day Year<br>July 9, 1996                                   |  | 3. Time of Death<br>9:04 PM  |   |
| 4a. Facility Name (If not institution, give street and number)<br>Suburban Hospital  |  |  |   |  |                                | 4b. City, Town, or Location of Death<br>Bethesda                                     |  | 4c. County of Death<br>Montgomery  |   |
| 5. Social Security Number<br>216 46 6576   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>85 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>July 27, 1910                                 |  | 9. Birthplace (State or Foreign Country)<br>Connecticut  |   |
| Usual Residence of Decedent  |  |  |   |  |                                |  |  |  |   |
| 10a. State<br>Maryland   |  | 10b. County<br>Montgomery  |   | 10c. City, Town or Location<br>Rockville   |                                |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br>12615 Circle Drive   |  |  |   | 10f. Zip Code<br>20850   |                                | 10g. Citizen of What Country?<br>United States                                       |  |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |                                |  | 16b. Kind of Business/Industry<br>Own Home   |  |   |
| 17. Father's Name (First, Middle, Last)<br>Louis Koehler   |  |  |   |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Marie Branch                    |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>David K. Nickels (Son)   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4317 Puller Drive, Kensington, Maryland 20895   |                                |  |  |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montgomery Crematorium Inc. |  |                                | Date<br>July 12, 1996  |  | 20c. Location - City or Town, State<br>Bethesda, Maryland  |   |
| 21. Signature of Funeral Service Licensee<br> M00335   |  |  |   | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/ Rockville, Inc.<br>300 West Montgomery Avenue<br>Rockville, Maryland 20850  |                                |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head trauma. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute Leukemia<br>Due to (or as a consequence of):<br>b. Sepsis<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |                                |  |  |  | Approximate Interval Between Onset and Death<br>Weeks   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|  |  |  |   |  |                                |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br>J40216  |                                | 29d. Date signed (Month, Day, Year)<br>7/11/96                                       |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis A. Cullen, M.D. 5454 Wisconsin Avenue, Chevy Chase, Maryland 20815  |  |  |   |  |                                |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>JUL 12 1996   |  |  |   | 32. Registrar's Signature<br>   |                                |  |  |  |   |

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

96 21959

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |  |  |  |
|--|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>MAXINE MORGAN NELSON                      |   |  |   | 2. Date of Death<br>Month Day Year<br>July 6, 1996                 |  | 3. Time of Death<br>7:15 p.m.  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>HOLY CROSS HOSPITAL |   |  |   | 4b. City, Town, or Location of Death<br>Silver Spring              |  | 4c. County of Death<br>Montgomery  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>578-40-2361  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>67 Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                     | 8. Date of Birth (Month, Day, Year)<br>Feb. 22, 1929   |  | 9. Birthplace (State or Foreign Country)<br>North Carolina |  |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |  |  |
| 10a. State<br>N/A  |   | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>Washington, D.C.   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br>6101 16th Street, N.W.   |   |   |  | 10f. Zip Code<br>20011  |  | 10g. Citizen of What Country?<br>United States   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Mathematical Statistician  |  |  | 16b. Kind of Business/Industry<br>Internal Revenue Ser. Federal Government                         |  |  |
| 17. Father's Name (First, Middle, Last)<br>Brookshire Morgan   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Camoline Christian   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Sampson Nelson   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6101 16th Street, N.W., Washington, D.C. 20011   |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Cemetery |   | 20c. Location - City or Town, State<br>7/11/96 Brentwood, Maryland |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Larry S. McGuire</i>   |   |   |  | 22. Name and Address of Facility<br>McGuire Funeral Service, Inc.<br>7400 Georgia Ave. N.W., Washington, D.C. 20012   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ACUTE PULMONARY EMBOLISM<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br>12 Hours   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>BRONCHIAL ASTHMA<br>HYPERTENSION   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  | 29b. Signature and title of certifier<br><i>Larry S. McGuire</i>  |  | 29c. License number<br>D0735   |  | 29d. Date signed (Month, Day, Year)<br>7/7/96              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DENNIS J. HAND MD 4600 Connecticut Ave N.W. Washington D.C. 20008  |   |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 09 1996   |   |   |  | 32. Registrar's Signature<br><i>John Davidson</i>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21960

Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |  |  |
|--|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HENRY VICTOR NECKER</b>                  |   |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>4</b> Year <b>1996</b> |  | 3. Time of Death<br><b>9:35 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Elkton</b>               |  | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-07-1152</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                      | 8. Date of Birth (Month, Day, Year)<br><b>May 24, 1908</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                          |
|  | Usual Residence of Decedent   |   |  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Edgewood</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1803 Nuttall Avenue</b>   |   |   |  | 10f. Zip Code<br><b>21040</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>   |   | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Martin A. Necker</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Christine (nmn) Neumeister</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen E. Necker - Wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1803 Nuttall Avenue, Edgewood, Md. 21040</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Grdns.</b>  |  | Data<br><b>7-8-96</b>  |   | 20c. Location - City or Town, State<br><b>Bel Air, Maryland</b>  |  |  |
| 21. Signature of Funeral Service Licensed<br><i>Howard K. McComas III</i>  |   |   |  | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Rd., Abingdon, Md. 21009</b>  |   |  |  |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Bronchopneumonia -</b><br>Due to (or as a consequence of):<br><b>b. Pulmonary Embolism - Suspected</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>10 days -</b><br><b>10 days -</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Arterial Disease</b><br><b>Carcinoma of prostate</b><br><b>Hypothyroidism -</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br><i>Asperitilal K. Patel MD</i>   |  | 29c. License number<br><b>D22307</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>7/5/96 -</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SAYANTILAL K. PATEL MD 123 Singuly Ave, ELKTON, MD 21921 -</b>  |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 8 1996</b>   |   | 32. Registrar's Signature<br><i>John Andrew Randall</i>   |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

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18, 20

96 21961

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES NORMAN NORRIS</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 13, 1996</b>  |  | 3. TIME OF DEATH<br><b>9:47 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-22-0479</b>   |  | 5. SEX<br><b>1 M 2 F</b>  |  | 6. AGE (In yrs. last birthday)<br><b>71 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb 18, 1925</b>                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>540 Indian Bridge Road</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>California</b>  |  | 9c. COUNTY OF DEATH<br><b>St. Mary's</b>                                   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>St. Mary's</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>California</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 X NO</b>                            |  |
| 10e. STREET AND NUMBER<br><b>540 Indian Bridge Road</b>   |  |   |  | 10f. ZIP CODE<br><b>20619</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 X YES 2 NO</b><br>IF YES, GIVE WAR OR DATES<br><b>World War II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 X NO</b> Specify:       |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10th Grade</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Farm</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elmer A. Norris</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Violet Bean</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Evelyn Norris</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>540 Indian Bridge Rd., California, MD 20619</b> |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify)</b>   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Face Cemetery 7/16/96</b>  |  | 20c. LOCATION — City or Town, State<br><b>Great Mills, MD</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael H. Gardiner</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b><br><b>Card. of Lung</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>C.D. R.D. - AERIAL</b>   |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 X NO</b>   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 X NO</b>  |  |   |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH <b>YES X NO</b> <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 X NO</b>   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                                  |  |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Patrick Jarboe, M.D.</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D 06449</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7-15-96</b>                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. Patrick Jarboe, M.D. Leonardtown, MD 20650</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 16 1996</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

96 21962

|   |  |   |   |  |  |  |   |  |  |
|---|--|---|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mary O'Hagan</b>  |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>7</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>11:10P.</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Laurel Regional Hospital</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>  |  | 4c. County of Death<br><b>Prince George's</b>   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-30-7587</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>November 16, 1927</b>   | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>  |  |
|   | Usual Residence of Decedent  |   |   |  |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>College Park</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
|   | 10e. Street and Number<br><b>9501 50th Place</b>   |   |   |  | 10f. Zip Code<br><b>20740</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>own home</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>David B. Logan</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary S. Frank</b>  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marie Thornton (daughter)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6456 Meadowlark Drive Dunkirk, Maryland 20754</b>  |  |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  | Date<br><b>7/11/1996</b>   |  | 20c. Location - City or Town, State<br><b>Silver Spring, Md.</b>  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Donald V. Borgwardt</i>  |   |   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Md. 20705</b>   |  |   |  |  |
|   | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Small bowel Obstruction</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |   |   |  |  |  |   | Approximate Interval Between Onset and Death<br><b>2 weeks</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of injury<br>M                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>A. Kunkrat</i>  |   |  |  |  |   |  |  |
| 29c. License number<br><b>036716</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/8/96</b>  |   |  |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A. Kunkrat 8317 CERRY LANE, LAUREL, MD. 20707</b>  |  |   |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

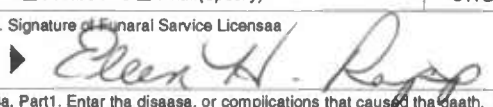
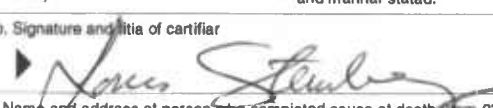
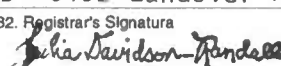
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21963  
Certificate of Death

Reg. No.

|   |   |   |   |   |   |  |  |   |
|---|---|---|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>KATHRYN LOUISE O'TOOLE  |   |   |   | 2. Date of Death<br>Month Day Year<br>July 11, 1996 |  | 3. Time of Death<br>11:10 A.M.         |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Larkin Chase Nursing & Restorative Center |   |   |   | 4b. City, Town, or Location of Death<br>Bowie       |  | 4c. County of Death<br>Prince George's |   |
| Funeral<br>Director   | 5. Social Security Number<br>526-01-8487  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>85 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Birth (Month, Day, Year)<br>Jan. 2, 1911  |  | 9. Birthplace (State or Foreign Country)<br>Arizona |
|   | Usual Residence of Decedent   |   |   |   |   |  |  |   |
| 10a. State<br>Maryland  |   | 10b. County<br>Prince George's  |   | 10c. City, Town or Location<br>Bowie  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |
| 10e. Street and Number<br>8600 Tabb Court   |   |   |   | 10f. Zip Code<br>20720  |   | 10g. Citizen of What Country?<br>United States   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collegia (1-4 or 5+) 2   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary  |   | 16b. Kind of Business/Industry<br>Wholesale Grocery  |  |   |
| 17. Father's Name (First, Middle, Last)<br>Harvey Alfred Frederick Severinghaus   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Louise Weber   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Julia K. Jackson  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8600 Tabb Court, Bowie, Maryland 20720   |   |  |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |   | Data<br>7-12-96   |   | 20c. Location - City or Town, State<br>Beltsville, MD  |  |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br>Rapp Funeral Services, P.A.<br>933 Gist Ave. Silver Spring, MD 20910  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Carcinoma of the Colon</u><br>Due to (or as a consequence of):<br>b. <u>Chronic Obstructive Pulmonary Disease</u><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |   |   |  |  | Approximate Interval Between Onset and Death        |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Parkinson's Disease</u>  |   |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|   |   |   |   |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |
|   |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |   |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   | 28d. Describe how injury occurred   |   |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and Title of certifier<br>  |   | 29c. License number<br>D12015   |   | 29d. Date signed (Month, Day, Year)<br>July 11, 1996   |  |   |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br>Louis E. Steinberg, MD 6492 Landover Rd. Landover, MD 20785   |   |   |   |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>JUL 12 1996  |   | 32. Registrar's Signature<br>  |   |   |   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21964

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |   |  |
|---|--|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Jerry H. Opack</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>July 5, 1996</b>  |  | 3. Time of Death<br><b>10:30am</b>  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>8708 Yarmouth Ct.</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Potomac</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-44-3910</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 9, 1935</b>                      |   | 9. Birthplace (State or Foreign Country)<br><b>Washington DC</b>   |
|   | Usual Residence of Decedent  |  |   |   |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  | 10b. County<br><b>Montgomery</b>   |   | 10c. City, Town or Location<br><b>Potomac</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   | 10a. Street and Number<br><b>8708 Yarmouth</b>   |  |   | 10f. Zip Code<br><b>20854</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                            |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Attorney</b>                      |   |  | 16b. Kind of Business/Industry<br><b>Legal</b>                                   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Theodore Opack</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sadye Furr</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Larry Opack/Son</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8708 Yarmouth Ct., Potomac, MD 20854</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Judean Memorial Gardens</b>  |   | Date<br><b>7/7/96</b>  |  | 20c. Location - City or Town, State<br><b>Olney, MD</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Edward Sagel Funeral Direction<br/>1091 Rockville Pike, Rockville MD 20852</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Gastric Carcinoma</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |   |  |  |   | Approximate Interval Between Onset and Death<br><b>2 years</b>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)                                     |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how Injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   | 29b. Signature and title of certifier<br>  |  |  |   | 29c. License number<br><b>D07568</b>   |
| 29d. Date signed (Month, Day, Year)<br><b>July 5, 1996</b>  |  |  |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Frederick Meyers, MD, 6860 Tulip Hill Terrace, Bethesda, Maryland, 20816</b>   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>   |  |  |   | 32. Registrar's Signature<br>  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 21965

Reg. No.

|                                     |   |  |   |  |   |  |  |  |  |  |   |  |
|-------------------------------------|---|--|---|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Edna Elizabeth Owens</b>   |  |   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>8</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>4:20 AM</b>   |  |   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>  |  |   |  |   |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>  |  | 4c. County of Death<br><b>Harford</b>  |  |   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>211-16-0041</b>   |  | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  |   |  |
|                                     | 6. Date of Birth (Month, Day, Year)<br><b>Dec. 16, 1903</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Cecil</b>  |  | 10c. City, Town or Location<br><b>Port Deposit</b>                           |  |   |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>      |  |   |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>Twelve Years</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic Help</b>   |  | 16b. Kind of Business/Industry<br><b>Private Residences</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Edward L. Kell</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Brown</b>       |  |   |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Alice O. Jones (Daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Box 234, Perry Point, Maryland 21902</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cokesbury Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>7/13/96 Port Deposit, Maryland</b> |  |   |  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Thomas M. Patterson, Sr.</b>  |  | 22. Name and Address of Facility<br><b>Lee A. Patterson &amp; Son Funeral Home</b><br><b>Perryville, Maryland 21903</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Cerebral hemorrhage</b><br>Due to (or as a consequence of):<br>b. <b>Hypertension &amp; atherosclerosis</b><br>Due to (or as a consequence of):<br>c. <b>Cardiovascular disease</b><br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death   |  |  |  |   |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown        |  |  |  |   |  |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Brian T. Yeo M.D.</b>   |  | 29c. License number<br><b>DIS152</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/8/96</b>   |  |  |  |   |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Brian T. Yeo, M.D., 801 South Union Avenue, Havre de Grace, Maryland 21078</b>   |  |   |  |   |  | 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>  |  |  |  | 32. Registrar's Signature<br><b>J. Davidson-Randall</b>                                     |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21966

|  |  |   |  |   |   |   |   |  |  |
|--|--|---|--|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Rushia K. Owens</b>                           |   |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>3</b> Year <b>1996</b> |   | 3. Time of Death<br><b>12:30P.M.</b>                        |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>11417 Allview Drive</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Beltsville</b>           |   | 4c. County of Death<br><b>Prince George's</b>               |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-34-7047</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.                    |   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 15, 1900</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                  |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince George's</b>                               |   | 10c. City, Town or Location<br><b>Beltsville</b>            |  |  |
| Usual Residence of Decedent  |  | 10d. inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>11417 Allview Drive</b>  |   | 10f. Zip Code<br><b>20705</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b>4</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Statistician</b>                  |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>  |   |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Hector Keener</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>unknown</b>   |   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara V. Lagle (Daughter)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as #10</b>   |   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>George Washington Cemetery</b>                                       |  | Date<br><b>7/8/1996</b>   |   | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>                             |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Donald V. Borgwardt</i>  |  |   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>   |   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. COMMUNITY ACQUIRED PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  |   |  |   |   |   |   | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |   |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                                  |  | 28. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                    |   |   |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>Neil A. Meade</i>   |  | 29c. License number<br><b>019820</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>July 3, 1996</b>                                  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Neil A. Meade, M.D. 9811 Mallard Drive Laurel, Maryland 20708</b>   |  |   |  |   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>  |  | 32. Registrar's Signature<br><i>Kia Davidson-Rodgers</i>  |  |   |   |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 5025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

96 21967

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>IRMGARD ANNA PATZIG</b>  |  |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>09</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>6:20 am</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>BEL FOREST NURSING AND REHABILITATION<br/>109 FOREST VALLEY DRIVE</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>FOREST HILL</b>  |  | 4c. County of Death<br><b>HARFORD</b>   |  |
| 5. Social Security Number<br><b>579-38-8661</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>June 4, 1903</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Germany</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Bel Air</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>308 Lakeside Dr.</b>  |  | 10f. Zip Code<br><b>21015</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Hermann (nmn) Nestmann</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Meta (nmn) Weissbach</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Edith K. Neeper - Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>308 Lakeside Dr., Bel Air, Md. 21015</b>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R. A. Ferris &amp; Co.</b>   |  | 20c. Date<br><b>7-10-96</b>  |  | 20d. Location - City or Town, State<br><b>W. Chester, Pa.</b>   |  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |
| 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>50 W. Broadway St., Bel Air, Md. 21014</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Critical Aortic Stenosis</b> |  | 23b. Approximate Interval Between Onset and Death<br><b>two years</b>   |  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |
| 23d. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 23e. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 25. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |
| 26. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 27a. Date of Injury (Month, Day, Year)   |  | 27b. Time of Injury<br><b>M</b>   |  | 27c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 27d. Describe how injury occurred   |  | 27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 27f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 28a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
| 28b. Signature and title of certifier<br><i>[Signature]</i>   |  | 28c. License number<br><b>d35522</b>   |  | 28d. Date signed (Month, Day, Year)<br><b>July 9, 1996</b>  |  | 29. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Mark Wild 2 North Avenue Bel Air Maryland 21014</b>  |  |
| 30. Date filed (Month, Day, Year)<br><b>JUL 11 1996</b>   |  | 31. Registrar's Signature<br><i>[Signature]</i>  |  | 32. Registrar's Name<br><b>John Davidson-Randall</b>  |  | 33. Registrar's Title<br><b>Registrar</b>   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



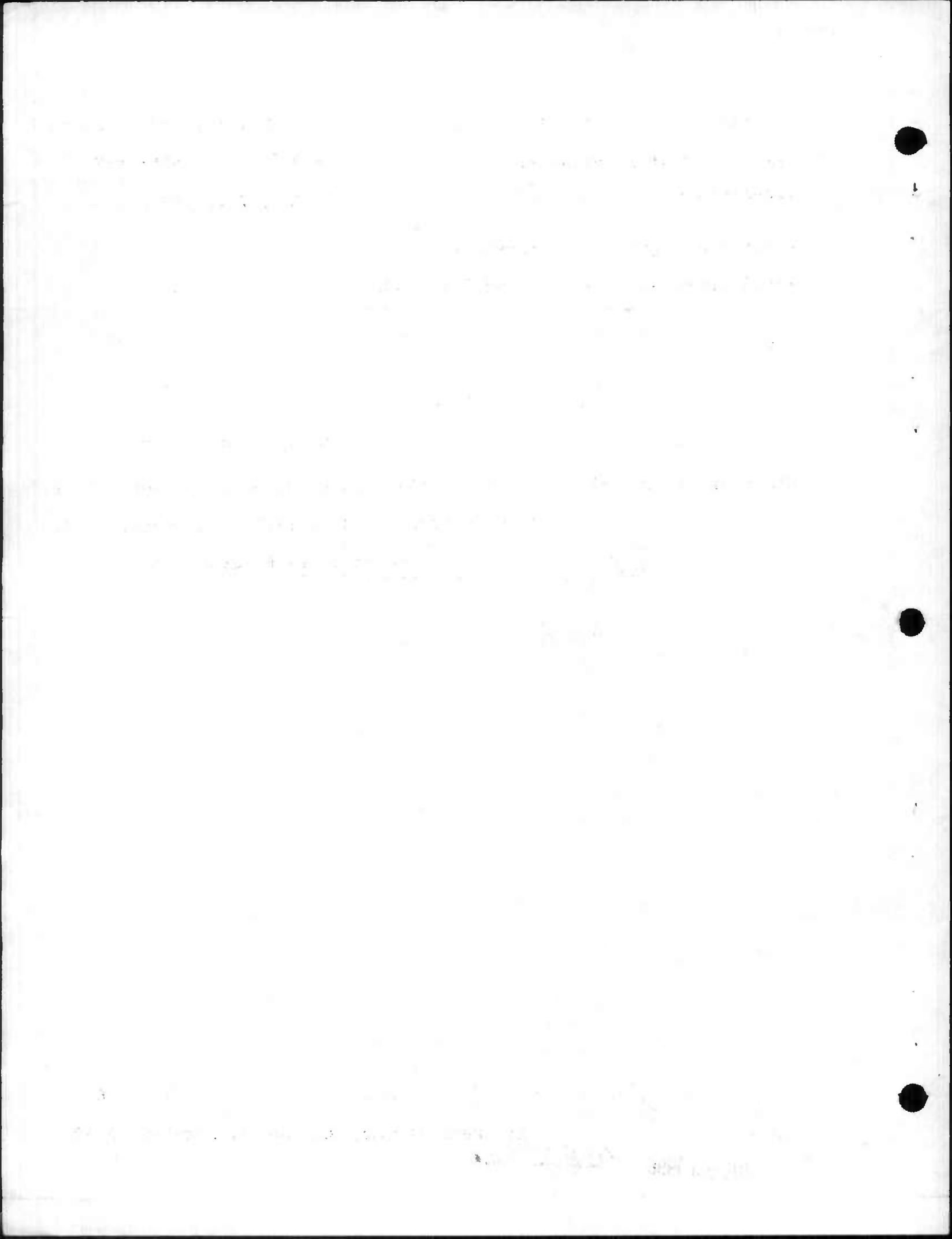
## Certificate of Death

Reg. No.

|   |  |   |  |                                |  |
|---|--|---|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ELMER PIFER Sr.</b>   |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>15</b> Year <b>1996</b>   |                                | 3. Time of Death<br><b>12:40 P</b>   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>SACRED HEART HOSPITAL ER</b>  |   | 4b. City, Town, or Location of Death<br><b>Cumberland</b>  |                                | 4c. County of Death<br><b>ALLEGANY</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-12-8688</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                          | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 27, 1921</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |                                |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent  |   | 10e. State<br><b>Maryland</b>  |                                |  |
|   | 10b. County<br><b>Allegany</b>   |   | 10c. City, Town or Location<br><b>Frostburg</b>  |                                |  |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |                                |  |
|   | 10f. Street and Number<br><b>14400 Upper Georges Creek Rd. SW.</b>   |   | 10g. Zip Code<br><b>21532</b>  |                                | 10h. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |                                |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Miner</b>  |                                | 16b. Kind of Business/Industry<br><b>Coal</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lettie Mae Pifer</b>   |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elmer Pifer Jr. -son</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12801 Vale Summit Rd. S.W. Frostburg, Md. 21532</b>  |                                |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Cemetery</b>  |                                | 20c. Location - City or Town, State<br><b>July 18, 1996 Lonaconing, Md.</b>  |
| 21. Signature of Funeral Service Licensee<br> |  | 22. Name and Address of Facility<br><b>Eichhorn-McKenzie Funeral Home<br/>Lonaconing, Md. 21539</b> |  |                                |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |  |                                | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how Injury occurred  |                                |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |                                |  |
|   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>OCME</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>JULY 16, 1996</b>  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |                                |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br><b>JUL 24 1996</b>  |   | 32. Registrar's Signature<br>  |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



96 21969

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SHANNON GABRIELLE PONEY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>July</b> DAY <b>6</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>9:00 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-37-5117</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>3</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 1, 1992</b>                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mt. Washington Pediatrics Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                |  |
| 9c. COUNTY OF DEATH<br><b>Maryland</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  |   |  |
| 10b. COUNTY<br><b>Montgomery</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Kensington</b>  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>3121 University Boulevard, West Unit 3</b>   |  |   |  |
| 10f. ZIP CODE<br><b>20895</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>None</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>None</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Poney</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Arlette D. Poney</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3121 University Boulevard, West Unit 3 Kensington, MD 20895</b>                             |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery 7/9/96 Silver Spring, Maryland</b>   |  | 20c. LOCATION — City or Town, State   |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W. Sil. Spr., MD 20901</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AIDS</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. <b>INFECTION</b><br>c.<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Melencio C. Ventura Jr M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D46506</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7-6-96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Melencio C. Ventura Jr 19504 Middletown Rd, FreeLand, Md 21053</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 10 1996</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ST. JOHN BOM

ST. JOHN BOM

ST. JOHN BOM

ST. JOHN BOM

ST. JOHN BOM



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21970

## Certificate of Death

Reg. No.

|  |   |  |  |   |  |                          |   |  |
|--|---|--|--|---|--|--------------------------|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Jane H. Potter  |  |  |   | 2. Date of Death<br>Month Day Year<br>July 4, 1996   |                          | 3. Time of Death<br>7:00 AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>4800 Chevy Chase Drive, #206  |  |  |   | 4b. City, Town, or Location of Death<br>Chevy Chase  |                          | 4c. County of Death<br>Montgomery   |  |
| Funeral<br>Director  | 5. Social Security Number<br>325-20-6586  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>75 Yrs.  |                          | 8. Date of Birth (Month, Day, Year)<br>Feb. 21, 1921  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Illinois  |  | 10a. State<br>Maryland   |   | 10b. County<br>Montgomery  |                          | 10c. City, Town or Location<br>Chevy Chase  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   | 10e. Street and Number<br>4800 Chevy Chase Drive, #206   |                          | 10f. Zip Code<br>20815  |  |
|  | 10g. Citizen of What Country?<br>United States  |  |  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |                          | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 10                              |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Professor  |  |  |   | 16b. Kind of Business/Industry<br>University   |                          |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Earl D. Huntington   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Ellen Powers   |                          |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>L. Dalton Potter  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1221 Allison Drive, Rockville, MD 20850   |                          |   |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory   |                          | 20c. Location - City or Town, State<br>7-5-96 Beltsville, Maryland  |  |
|  | 21. Signature of Funeral Service Licensee<br>Eileen H. Rapp   |  |  |   | 22. Name and Address of Facility<br>Rapp Funeral Services, P. A.<br>933 Gist Avenue, Silver Spring, MD 20910   |                          |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cancer of lung with metastasis<br>Due to (or as a consequence of):<br>b. Tobacco abuse<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   | Approximate Interval Between Onset and Death<br>9 months   |                          |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic Obstructive Pulmonary Disease of 20+ years<br>Hypothyroidism  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                          |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                          |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of injury<br>M |   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  | 28d. Describe how injury occurred   |  |                          |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |                          |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  | 29b. Signature and title of certifier<br>J. V. Young M.D.   |  |                          |   |  |
| 29c. License number<br>DC 8112   |   |  |  | 29d. Date signed (Month, Day, Year)<br>July 5, 1996   |  |                          |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David V. Young, M. D., 4530 Connecticut Avenue, NW, Washington, DC 20008-4318  |   |  |  | 31. Data filed (Month, Day, Year)<br>JUL 08 1996  |  |                          |   |  |
| 32. Registrar's Signature<br>John Davidson-Pondell   |   |  |  | 33. State Registrar   |  |                          |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



96 21971

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |   |
|--|--|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>William Calvin Potter  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 11, 1996   |  | 3. TIME OF DEATH<br>9:20 A.M.   |   |
| 4. SOCIAL SECURITY NUMBER<br>219-12-3201   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>73 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>Jul 14, 1922   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Charlotte Hall Veterans Home   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Charlotte Hall   |  | 9c. COUNTY OF DEATH<br>St. Mary's   |   |
| RESIDENCE OF DECEDENT  |  |  |   |   |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>St. Mary's  |   | 10c. CITY, TOWN OR LOCATION<br>Leonardtown  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>RR 2, 1 Dorsey St. Newtowne Village #213   |  |  |   | 10f. ZIP CODE<br>20650  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th Grade  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Trouble Shooter   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Electric Company  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Henry Wathan Potter   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Cora Elizabeth Owens   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Marilyn Mae Potter   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>RR 2, 1 Dorsey St #213, Leonardtown, MD 20650  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Charles Memorial Gardens 7/15/96  |   | 20c. LOCATION — City or Town, State<br>Leonardtown, Maryland  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael L. Gardner</i>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. Chronic Arteriosclerotic<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |   |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |   |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Emad R. Al-Banna</i>   |  |  |   | 29c. LICENSE NUMBER<br>D12705   |  | 29d. DATE SIGNED (Month, Day, Year)<br>July 11, 1996  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Emad R. Al-Banna, M.D. Prince Frederick, MD 20678   |  |  |   |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>JUL 19 1996   |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>Julia Anderson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



96 21972

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edwin Springer Preble</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>July</b> DAY <b>12</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>11:44 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>205-01-1271</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08/03/1917</b>  |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Longview Nursing Home</b>   |  |   |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Manchester</b>   |  | 9b. COUNTY OF DEATH<br><b>Carroll</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Carroll</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Westminster</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>200 Bell Road</b>   |  | 10f. ZIP CODE<br><b>21158</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE - American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                        |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Engineer</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Shell Oil</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harold Preble</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence Burt</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elsie M. Preble</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 Bell Road, Westminster, MD 21158</b>                                   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Carroll Cremations, Inc. Hampstead, MD</b>   |  | 20c. LOCATION - City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Katherine Pritts - Switzer</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Pritts Funeral Home &amp; Chapel<br/>412 Washington Rd., Westminster, MD</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SMALL CELL CARCINOMA - Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>WITH METASTASIS LIVER</b><br>Approximate Interval Between Onset and Death <b>1 yr</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28d. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W. H. F. M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>DO 3386</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/12/96</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>W. H. F. M.D. 3223 MAIN ST, MANCHESTER, MD 21102</b>  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 15 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21973

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Maria Raimondo Ramella

2. Date of Death

Month Day Year  
July 6, 1996

3. Time of Death

7:15 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

610 Pershing Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-52-1625 A

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 7, 1910

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedant

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

610 Pershing Drive

10f. Zip Code

20910

10g. Citizen of What Country?

Italy

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedant Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedant's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedant's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Domenico Raimondo

18. Mother's Name (First, Middle, Maiden Surname)

Caterina Aschero

19a. Informant's Name/Relationship (Type, Print)

Bernardo Ramella/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2601 Evans Dr., Silver Spring, Md. 20902

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gazzelli Cemetery

Date

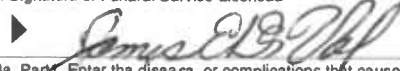
July 17,

1996

20c. Location - City or Town, State

Gazzelli, Imperia, Italy

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

DeVol Funeral Home

2222 Wisconsin Ave., N.W. Washington, DC 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. metastatic ovarian cancer

Due to (or as a consequence of):

b. ovarian tumor

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

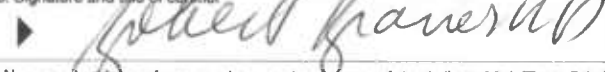
M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D05937

29d. Date signed (Month, Day, Year)

July 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Kramer, M.D. 10313 Georgia Ave., Silver Spring, Md.

31. Date filed (Month, Day, Year)

JUL 09 1996

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





96 21974

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Elizabeth Bosse Ramsay   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 9, 1996   |  | 3. TIME OF DEATH<br>5:15 A.M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>577-62-3670  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>94 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>August 21, 1901  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>South Carolina  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Montgomery General Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Olney   |  |
| 9c. COUNTY OF DEATH<br>Montgomery   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  |
| 10c. CITY, TOWN OR LOCATION<br>Silver Spring  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>3551 South Leisure World Boulevard   |  |
| 10f. ZIP CODE<br>20906  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (8-12) College (1-4 or 5+) 5+  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Louis Hinnant Bosse  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Cora Bosse  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>James B. Ramsay (son)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 82, Orlean, Virginia 20128   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>July 12, 1996<br>Montgomery Crematorium Inc.   |  | 20c. LOCATION — City or Town, State<br>Bethesda, Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John P. Chapman M00092   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert A. Pumphrey Funeral Home/Rockville, Inc.<br>300 West Montgomery Avenue<br>Rockville, Maryland 20850   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Uro Septicemia<br>b. Urinary Tract Infection<br>c. Sequentielly ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Concussive Head Fracture |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Benjamin J. Arunow, MD   |  |  |  | 29c. LICENSE NUMBER<br>1808381   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>July 9, 1996   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Benjamin J. Arunow, MD 18111 Prince Philip Dr., Arago Rd.   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 12 1996  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM: 14. PER F.H. FILM G-738 8/13/96 t.t

96 21975

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Pearl</b>   |  | 2. DATE OF DEATH<br>MONTH <b>July</b> DAY <b>06</b> YEAR <b>1996</b>   |  | 3. TIME OF DEATH<br><b>2:50 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-22-2091</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.   |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 24, 1924</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2404 Hannah Road.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Churchville</b>  |  | 9c. COUNTY OF DEATH<br><b>Harford</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Harford</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Churchville</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2404 Hannah Road</b>  |  | 10f. ZIP CODE<br><b>21028</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White<br>Specify: <b>BLACK</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Francis Dorsey</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Evelyn Estella Jones</b>   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Lee Dorsey</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>502 Camelot Drive, Bel Air, Maryland 21015</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>R. A. Ferris &amp; Co., Inc. 7/8/96 West Chester, PA</b>   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Howard K. McComas III</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Md. 21009</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Arteriosclerotic Cardiovascular Disease</b>  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>G. S. Prabhu</i> DME   |  | 29c. LICENSE NUMBER<br>OCME  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>July 06, 1996</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>G.S. Prabhu M.D. 1810 Belair Rd # 102 Fallston MD. 21047410-879-6564</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>JUL 8 1996</b>   |  |
| 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Restall</i>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 96 21976

## Certificate of Death

Reg. No.

|  |   |   |   |   |  |   |   |                                   |  |  |
|--|---|---|---|---|--|---|---|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>JOYLIN CLONEL REED  |   |   |   | 2. Date of Death<br>Month Day Year<br>JULY 5 1996  |   |   |                                   | 3. Time of Death<br>7:18 AM                        |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>NATIONAL NAVAL MEDICAL CENTER   |   |   |   | 4b. City, Town, or Location of Death<br>BETHESDA   |   |   |                                   | 4c. County of Death<br>MONTGOMERY                  |  |
| Funeral<br>Director  | 5. Social Security Number<br>267-33-4076  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>45 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>July 4, 1951   |                                   | 9. Birthplace (State or Foreign Country)<br>Guyana |  |
|  | Usual Residence of Decedent   |   |   |   | 10. City, Town or Location<br>Lorton   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Virginia  |   | 10b. County<br>Fairfax  |   | 10c. City, Town or Location<br>Lorton  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                   |  |  |
|  | 10e. Street and Number<br>7311 Whernside Court  |   |   |   | 10f. Zip Code<br>22079   |   | 10g. Citizen of What Country?<br>USA  |                                   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: African American   |                                   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collage (1-4 or 5+)   |   |   |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cost Control Analyst  |   | 16b. Kind of Business/Industry<br>Fairfax County Schl.  |                                   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Clinton Assaye   |   |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br>Cicely Princess Blair   |   |   |                                   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Solomon Reed  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7311 Whernside Ct., Lorton, Va. 22079   |   |   |                                   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cem.   |   | 20c. Location - City or Town, State<br>Arlington, Va.  |   |   |                                   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>R/M/J.   |   |   |   | 22. Name and Address of Facility<br>MONEY & KING VIENNA FUNERAL HOME, INC.<br>171 W. Maple Ave., Vienna, Va. 22180   |   |   |                                   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. PULMONARY FIBROSIS<br>Due to (or as a consequence of):<br><br>b. SCLERODERMA<br>Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |   |   |   | Approximate Interval Between Onset and Death   |   |   |                                   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                   |  |  |
|  |   |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |   |                                   |  |  |
|  |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |                                   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA |   | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |   |                                   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred |  |  |
|  |   | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |                                   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>Stephen P. Deaton  |   | 29c. License number<br>RES-000  |  | 29d. Date signed (Month, Day, Year)<br>July 5, 1996   |   |                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>S.E. MCINTYRE, LT, MC, USNR  |   |   |   | NATIONAL NAVAL MEDICAL CENTER<br>BETHESDA MD 20889-5600   |  |   |   |                                   |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 12 1996   |   | 32. Registrar's Signature<br>Julia Davidson-Randall   |   |   |  |   |   |                                   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes the need for transparency and accountability in all financial dealings.

2. The second part of the document outlines the various methods and techniques used to collect and analyze data. It includes a detailed description of the experimental procedures and the statistical analysis performed.

3. The third part of the document presents the results of the study. It includes a series of tables and graphs that illustrate the findings of the research. The data shows a clear trend of increasing activity over time.

4. The fourth part of the document discusses the implications of the findings. It suggests that the results have significant implications for the field of study and may lead to further research in this area.

5. The fifth part of the document concludes the study. It summarizes the main findings and provides a final statement on the importance of the research.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21977

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Viola Biddle Reynolds

2. Date of Death

Month

Day

Year

July

9

3. Time of Death

6:10 p.m.

1996

Cecil

North East

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Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3 Roney Avenue

4b. City, Town, or Location of Death

North East

4c. County of Death

Cecil

5. Social Security Number

199-18-3443

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 6, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

North East

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3 Roney Avenue

10f. Zip Code

21901

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

Law Office

17. Father's Name (First, Middle, Last)

James Biddle

18. Mother's Name (First, Middle, Maiden Summa)

Margaret McKinney

19a. Informant's Name/Relationship (Type, Print)

Carol E. Jamison

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

107 Garrett Road, Newark, Delaware 19713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

North East Methodist Cem.

Date

7/12/96

20c. Location - City or Town, State

North East, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Crouch Funeral Home

127 South Main Street, North East, MD 21901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. General vascular disease and infarct.

2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Red myocardial infarction

6 yr

Due to (or as a consequence of):

c. Cardiac arrhythmia

6 yr

Due to (or as a consequence of):

d. Red cerebral vascular infarct with hemorrhage 5 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. J. A. Hsu MD

29c. License number

D04623

29d. Date signed (Month, Day, Year)

7/11/96

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL-CAIH Hsu MD 203 W. Main St. ELKTON MD 21921

31. Date filed (Month, Day, Year)

JUL 11 1996

32. Registrar's Signature

Julia Davidson-Rodriguez

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

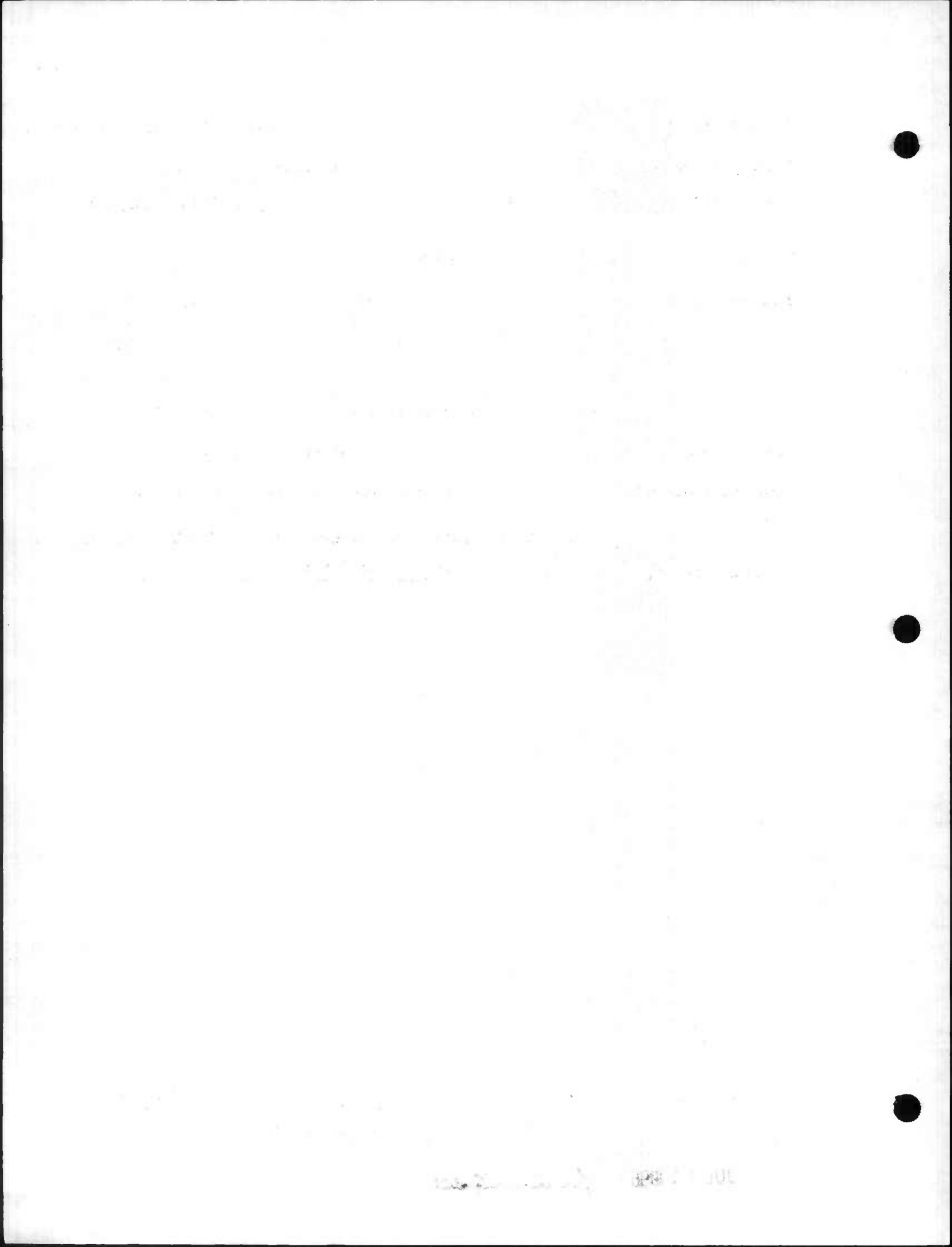
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21978

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>HOLTON EDWARD RHODES, SR.  |  |  |  | 2. Date of Death<br>Month Day Year<br>07 04 96   |  | 3. Time of Death<br>8:30 a.m.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Caroline Nursing Home, Inc.  |  |  |  | 4b. City, Town, or Location of Death<br>Denton   |  | 4c. County of Death<br>Caroline  |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-36-1766   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>90 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>MARCH 20, 1906  |  |
|   | 9. Birthplace (State or Foreign Country)<br>MD   |  | 10a. State<br>MARYLAND   |  | 10b. County<br>TALBOT  |  | 10c. City, Town or Location<br>QUEEN ANNE  |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br>29525 QUEEN ANNE HIGHWAY   |  | 10f. Zip Code<br>21657   |  | 10g. Citizen of What Country?<br>USA   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>FARMER  |  | 16b. Kind of Business/Industry<br>GRAIN FARM   |  | 17. Father's Name (First, Middle, Last)<br>EDWARD WASHINGTON RHODES  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>ELIZABETH HOPKINS   |  | 19a. Informant's Name/Relationship (Type, Print)<br>HOLTON E. RHODES, JR SON   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. BOX 275 WYE MILLS, MD 21679  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Other (Specify) |  |
| Physician<br>/Medical<br>Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ST. PETER'S CEMETERY   |  | 20c. Date<br>7/8/96  |  | 20d. Location - City or Town, State<br>QUEENSTOWN, MD  |  | 21. Signature of Funeral Service Licensee<br>M. E. Newman  |  |
|   | 22. Name and Address of Facility<br>FELLOWS, HELFENBEIN, & NEWNAM F.H.<br>200 S. HARRISON ST., EASTON, MD 21601  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. PNEUMONIA<br>Due to (or as a consequence of):<br>b. Congestive heart Failure<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death<br>Days   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Alzheimers Dementia<br>Parkinsons<br>Diabetes Mellitus   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>M 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>James Sides   |  | 29c. License number<br>D31376  |  | 29d. Date signed (Month, Day, Year)<br>7-5-96  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>James Sides 920 Market St Denton MD  |  | 31. Date filed (Month, Day, Year)<br>JUL 08 1996   |  | 32. Registrar's Signature<br>Julia Davidson-Randall  |  | State Registrar  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21979

## Certificate of Death

Reg. No.

|  |  |  |  |   |  |  |   |  |
|--|--|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ann G. Ritchell</b>                         |  |  |   | 2. Date of Death<br>Month Day Year<br><b>July 8 1996</b> |  | 3. Time of Death<br><b>3:45 p.m.</b>                        |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  | 4c. County of Death<br><b>Montgomery</b>                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>474-07-1017</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.         |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 8, 1916</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>St. Paul, MN</b>                            |  | 10a. State<br><b>NC</b>  |   | 10b. County<br><b>Forsyth</b>                            |  | 10c. City, Town or Location<br><b>Winston-Salem</b>         |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>2926 Buena Vista Road</b>  |  |  |   | 10f. Zip Code<br><b>27106</b>  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>1</b>   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |   | 17. Father's Name (First, Middle, Last)<br><b>Franklyn Gifford</b>   |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clementine Ryan</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Edward C. Ritchell</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2926 Buena Vista Rd., Winston-Salem, NC 27106</b>  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Comfort Crematory</b>  |  |  |   | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |
| 20d. Date<br><b>7/11/96</b>  |  |  |  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> <b>MB0946</b>   |  |  |   | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons, Inc.<br/>5130 Wisconsin Avenue, N.W.<br/>Washington, D.C. 20016</b>   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Intracerebral hemorrhage</b><br>Due to (or as a consequence of):<br><br>b. <b>Hypertension</b><br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>Unknown</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> <b>M.D.</b>  |  |  |  | 29c. License number<br><b>D39671</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 9<sup>th</sup> 1996</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PANKAJ LAL 11119 ROCKVILLE PIKE #100 ROCKVILLE MD 20852</b>   |  |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>  |  |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21980

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |  |  |  |
|--|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Naomi Camper Sampson                              |   |  |  | 2. Date of Death<br>Month 7 Day 7 Year 96  |  | 3. Time of Death<br>23 40  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Dorchester General Hospital |   |  |  | 4b. City, Town, or Location of Death<br>Easton   |  | 4c. County of Death<br>Talbot  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>220-01-4257  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>72 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Oct. 5, 1923  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|  | Usual Residence of Decedent   |   |  |  |  |  |  |  |  |
| 10a. State<br>Maryland   |   | 10b. County<br>Dorchester   |  | 10c. City, Town or Location<br>Hurlock   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>4714 Jones Village   |   |   |  | 10f. Zip Code<br>21643   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6th College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Machine Operator  |  |  | 16b. Kind of Business/Industry<br>Cold Water   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Alfred Henry Camper   |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lillie Ann Jenkins  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Jessie Camper  |   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1102 Race Street, Cambridge, Maryland 21613 |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)         |  | Date<br>7/13/96  |  | 20c. Location - City or Town, State  |  |  |
| 21. Signature of Funeral Service Licensee  |   |   |  |  | 22. Name and Address of Facility<br>Bennie Smith Funeral Home<br>P.O. Box 1687, Easton, Maryland 21601                                       |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Heart Failure<br>Due to (or as a consequence of):<br>b. Pulmonary Edema<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>24 hrs<br>24 hrs |   |   |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Transverse Myelitis  |   |   |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |  |  |  |  |  |  |  |
| 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred                    |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>William Bair  |   | 29c. License number<br>043238   |  | 29d. Date signed (Month, Day, Year)<br>7/8/96  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print)<br>William Bair 19 Franklin St. Cambridge, MD, 21613  |   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 10 1996   |   | 32. Registrar's Signature<br>Julia Davidson-Randall   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21981

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |   |  |
|--|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Edward Jennings Sale</b>  |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>8</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>11:42 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>704 Franklin Avenue</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>  |  | 4c. County of Death<br><b>Carroll</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-10-4028</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>March 17, 1915</b>                                |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Westminster</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>704 Franklin Avenue</b>  |  | 10f. Zip Code<br><b>21157</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>sales executive</b>                           |  | 16b. Kind of Business/Industry<br><b>dairy</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Rupert Hughes Sale</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Marie Kriener</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Enid Irene Morome, daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>704 Franklin Ave., Westminster, Md 21157</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |  | 20d. Date<br><b>7/11/96</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Katherine Pritts - Sweitzer</b>  |  |   |  | 22. Name and Address of Facility<br><b>Pritts Funeral Home &amp; Chapel<br/>412 Washington Rd., Westminster, MD 21157</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Ischemic Heart Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |   |  |
| State Registrar  | 29b. Signature and title of certifier<br><b>Norman E. Goldstein, M.D.</b>  |  |   |  | 29c. License number<br><b>D26385</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7-9-96</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Norman E. Goldstein, 218 Washington Heights Medical Center, Westminster Md.</b>   |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>  |  |  |   | 32. Registrar's Signature<br><b>John A. Anderson-Randall</b> |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21982

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Shirley Colleen Stephens   |  |   |  | 2. Date of Death<br>Month Day Year<br>July 7 1996  |  | 3. Time of Death<br>19:30  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>4702 Sotterly Lane   |  |   |  | 4b. City, Town, or Location of Death<br>Lothian  |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director  | 5. Social Security Number<br>484 20 5616   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>71 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>May 8, 1925   |  |
|  | 9. Birthplace (State or Foreign Country)<br>Iowa   |  | 10a. State<br>MD  |  | 10b. County<br>Anne Arundel  |  | 10c. City, Town or Location<br>Lothian   |  |
| To Be Completed by Funeral Director                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>4702 Sotterly Lane  |  | 10f. Zip Code<br>20711   |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Loan Officer   |  | 16b. Kind of Business/Industry<br>Banking  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Edward James Simmons  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Evallee Alice Collins   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Gail A. Short  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5222 Cottonwood Drive, Lothian, MD 20711  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Rosecrans Nat'l. Cem. 7-16-96 San Diego, CA   |  | 20c. Location - City or Town, State  |  |  |  |
|  | 21. Signature of Funeral Service Licensee  |  | 22. Name and Address of Facility<br>Rausch Funeral Home, Owings, MD 20736   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. METASTATIC SMALL CELL Lung Cancer 9 months<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. {<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28e. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |  |
|  | 29e. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29c. License number<br>D29294   |  |  |  |  |  |
|  | 29b. Signature and title of certifier  |  | 29d. Date signed (Month, Day, Year)<br>7/8/96   |  |  |  |  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Dr. Hughes 10810 Connecticut Ave., Kensington, MD  |  |   |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>JUL 10 1996   |  | 32. Registrar's Signature<br>John Davidson-Randall  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 9555.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21983

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |   |   |
|--|---|---|---|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>RUTH MORRIS Sheubrooks</b>   |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>9</b> Year <b>1996</b>  |  | 3. Time of Death<br><b>10:35 AM</b>                                     |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital at Easton</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>  |  | 4c. County of Death<br><b>Talbot</b>                                    |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-58-0563</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 22, 1908</b>             | 9. Birthplace (State or Foreign Country)<br><b>DELAWARE</b>             |
|  | Usual Residence of Decedent   |   |   |  |  |  |   |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>QUEEN ANNE'S</b>  | 10c. City, Town or Location<br><b>CENTREVILLE</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
|  | 10e. Street and Number<br><b>1201 JOHN BROWN ROAD</b>   |   |   | 10f. Zip Code<br><b>21617</b>                    |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>                     |  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>SHADRACK LAWRENCE MORRIS</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>NORA ANDERSON</b>  |  |   |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LARRY A. SHEUBROOKS/ SON</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>140 LOCUST GROVE FARM LANE, CENTREVILLE, MD</b>  |  |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESTERFIELD CEMETERY</b>  |  | Date<br><b>7-12</b>  |  | 20c. Location - City or Town, State<br><b>CENTREVILLE, MD</b>           |   |
|  | 21. Signature of Funeral Service Licensee<br><b>JOHN R. MERCER</b>  |   |   |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD</b>   |  |   |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |   | Approximate interval Between Onset and Death                            |
|  | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br>b. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br>c. <b>UPPER GASTROINTESTINAL BLEED</b><br>Due to (or as a consequence of):<br>d. <b>DIABETES MELLITUS</b> |   |   |  |  |  |   | <b>36 hrs</b><br><br><b>years</b><br><br><b>32h</b><br><br><b>years</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPOTENSION</b><br><b>ANEMIA</b>  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred                                       |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>Eric F. Ciganek, M.D.</b>   |   | 29c. License number<br><b>D35048</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>7/9/1996</b>   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ERIC F. CIGANEK, M.D., P.O. BOX 339, CENTREVILLE, MD 21617</b>  |   |   |   |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 1996</b>  |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |   |  |  |  |   |   |

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



## Certificate of Death

Reg. No.

|   |  |  |  |                                |  |
|---|--|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BROOKS SCHOOLFIELD</b>  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>06</b> Year <b>1996</b>   |                                | 3. Time of Death<br><b>1656 PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL HOSPITAL E.R.</b>  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |                                | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>229-27-5281</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>13</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 8, 1983</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |                                |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |  |                                |  |
|   | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Worcester</b>  | 10c. City, Town or Location<br><b>Pocomoke</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>7937 Dividen Creek Road</b>   |  | 10f. Zip Code<br><b>21851</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+) <b>Student</b>         |                                |  |
|   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |  | 17. Kind of Business/Industry<br><b>Pocomoke Jr. High Scho</b>   |                                |  |
|   | 18. Father's Name (First, Middle, Last)<br><b>Donald Collins</b>   |  | 19. Mother's Name (First, Middle, Maiden Surname)<br><b>Joyce Schoolfield</b>  |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joyce Schoolfield</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7937 Dividen Creek Road, Pocomoke, Md. 21851</b> |                                |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt Sinai Baptist Church 7/13/96</b>                                     |                                | 20c. Location - City or Town, State<br><b>Pocomoke, Maryland</b>   |
|   | 21. Signature of Funeral Service Licensee<br><i>John A. Drince</i>   |  | 22. Name and Address of Facility<br><b>Bennie Smith Funeral Home<br/>P.O. Box 1687, Easton, Maryland 21601</b>                                       |                                |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Drowning</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |                                |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiomyopathy LEFT VENTRICULAR HYPERTROPHY</b>   |  |  |                                |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |                                |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |                                |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |                                |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |                                |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |                                |  |
|   | 28a. Date of Injury (Month, Day, Year)<br><b>7/6/96</b> 28b. Time of Injury<br><b>1500 HR</b> 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how Injury occurred<br><b>Swimming and drowned</b>   |  |  |                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>pond</b> 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Pocomoke, Maryland</b>   |  |  |  |                                |  |
| 29a. Certifier<br>(Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |                                |  |
| 29b. Signature and title of certifier<br><i>Theodore McKing</i> 29c. License number<br><b>O.C.M.E</b> 29d. Date signed (Month, Day, Year)<br><b>JULY 7, 1996</b>  |  |  |  |                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE MCKING 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 11 1996</b> 32. Registrar's Signature<br><i>Gina Davidson-Randall</i>   |  |  |  |                                |  |

Baltimore, Maryland 21215-0020

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



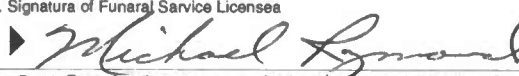
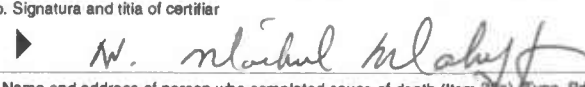
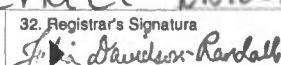
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21985

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |   |  |  |  |
|--|--|---|---|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Priscilla Arlene Settle</b>   |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>5</b> Year <b>1996</b>  |   |   |  | 3. Time of Death<br><b>0243</b>                        |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>  |   |   |  | 4c. County of Death<br><b>Calvert</b>                  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-22-5182</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   |   | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.                         |  |
|  | 8. Date of Birth<br>(Month, Day, Year)<br><b>JULY 19, 1925</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, DC</b>   |  | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>CALVERT</b>   |  | 10c. City, Town or Location<br><b>CHESAPEAKE BEACH</b> |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>3111 HIGHVIEW ROAD</b>   |  | 10f. Zip Code<br><b>20732</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ELECTRONIC TECH.</b>              |  | 16b. Kind of Business/Industry<br><b>U.S. GOVT.</b>  |   |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>LESLIE FRANKLIN SETTLE</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CAROLYN BLANZ</b>  |   |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DONALD SETTLE</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4459 OLD NATIONAL PIKE MT. AIRY, MD. 21771</b>   |   |   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SOUTHERN MEM. GARDENS</b>  |  | Data<br><b>7-6-96</b>  |   | 20c. Location - City or Town, State<br><b>DUNKIRK, MARYLAND</b>         |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL HOME<br/>DUNKIRK, MARYLAND 20754</b>  |   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Perforated Gastric and Duodenal Ulcers</b><br>Dua to (or as a consequence of):<br><b>b. Ischemic Bowel</b><br>Dua to (or as a consequence of):<br><b>c. Multiple System Organ Failure</b><br>Dua to (or as a consequence of):<br><b>d.</b> |   |   |  | Approximate Interval Between Onset and Death   |   |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b></b>   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |  |
| 28d. Describe how injury occurred<br><b></b>   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>                                      |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>     |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   | 29b. Signature and title of certifier<br> |  | 29c. License number<br><b>D47443</b>  |   |  |  |  |
| 29d. Data signed (Month, Day, Year)<br><b>7/5/96</b>   |  | 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><b>William Michael Mahaffey Prince Frederick, MD</b>  |   |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>  |  | 32. Registrar's Signature<br>  |   |  |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-692-0025.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21986

## Certificate of Death

Reg. No.

|  |  |  |   |                                |   |   |  |  |  |
|--|--|--|---|--------------------------------|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>EVELYN HURLEY SEABREASE  |  |   |                                | 2. Date of Death<br>Month Day Year<br>June 27 1996  |   | 3. Time of Death<br>8:45 pm                                      |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>University of Md. Medical System   |  |   |                                | 4b. City, Town, or Location of Death<br>Baltimore   |   | 4c. County of Death  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-03-2560   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>81 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Dec. 2 1914  |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|  | Usual Residence of Decedent  |  |   |                                |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD   | 10b. County<br>Dorchester  | 10c. City, Town or Location<br>Cambridge  |                                |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
|  | 10e. Street and Number<br>701 Race St.   |  |   | 10f. Zip Code<br>21613         |   | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: white |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4or 5+)   |  | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>homemaker                                |                                | 16b. Kind of Business/Industry<br>own home  |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Riley George Hurley   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Katherine Henry  |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>William T. Seabrease - husband   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>701 Race St., # 225 Cambridge, MD 21613  |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)              |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>East New Market Cemetery  |                                | Date<br>6/29  |   | 20c. Location - City or Town, State<br>E. New Market Md.         |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |                                | 22. Name and Address of Facility<br>Thomas Funeral Home PA<br>700 Locust St. Cambridge, MD 21613  |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |                                |   |   |  |  | Approximate Interval Between Onset and Death |
|  | Immediate Cause (Final disease or condition resulting in death)<br>a. CEREBRAL HERNIATION<br>Due to (or as a consequence of):<br>b. HYDROCEPHALUS<br>Due to (or as a consequence of):<br>c. MENINGEAL INFLAMMATION<br>Due to (or as a consequence of):<br>d. |  |   |                                |   |   |  |  | 3 DAYS<br>3 DAYS<br>4 DAYS                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |                                |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |                                |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M       |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   | 29c. License number<br>7301    |   | 29d. Date signed (Month, Day, Year)<br>July 5, 1996   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>DAVID HINTER MD 22 GROSVENOR ST. BALTIMORE MD 21201  |  |  |   |                                |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 1 1 1996  |  | 32. Registrar's Signature<br>  |   |                                |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



96 21987

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE SASLAW</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 4, 1996</b>  |  | 3. TIME OF DEATH<br><b>4:25 P. M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>107-76-5645</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-20-21</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>9333 Lanham Severn Road</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Seabrook</b>   |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>   |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>Prince George's</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>SEABROOK</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>9333 LANHAM SEVERN RD</b>   |  |   |  |
| 10f. ZIP CODE<br><b>20706</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 Years</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Merchant</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Restaurant &amp; Bar</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Abraham Saslaw</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sylvia Goldenhar</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert M. Saslaw</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>509 Skipper Court, Chester, Maryland 21619</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cheltenham Veterans Cemetery 7/09/1996</b>   |  | 20c. LOCATION — City or Town, State<br><b>Cheltenham, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stettinmeyer</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL ST, NW, WASHINGTON, DC 20012</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC MELANOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>6 WEEKS</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Elisabeth Iljas ONCOLOGY FELLOW</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>#D0050753</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/5/96</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ELISABETH ILJAS, JOHNS HOPKINS MEDICAL ONCOLOGY CENTER, BALTIMORE, MD</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 08 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Robert</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21988

|                                     |   |  |   |  |  |  |  |                                   |
|-------------------------------------|---|--|---|--|--|--|--|-----------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>GERHARD LODEWYK SCHROEDER   |  |   |  | 2. Date of Death<br>Month JULY Day 7, Year 1996  |  | 3. Time of Death<br>5:00 AM  |                                   |
|                                     | 4a. Facility Name (If not Institution, give street and number)<br>7716 HANOVER PARKWAY #204   |  |   |  | 4b. City, Town, or Location of Death<br>GREENBELT  |  | 4c. County of Death<br>PRINCE GEORGES  |                                   |
| Funeral<br>Director                 | 5. Social Security Number<br>218-82-6670  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>34 Yrs.   | If Under 1 Year<br>Months Days                     | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>DEC. 11, 1961  | 9. Birthplace (State or Foreign Country)<br>NETHERLANDS  |                                   |
|                                     | Usual Residence of Decedent   |  |   |  |  |  |  |                                   |
| To Be Completed by Funeral Director | 10a. State<br>MD.   | 10b. County<br>PRINCE GEORGES  | 10c. City, Town or Location<br>GREENBELT  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |                                   |
|                                     | 10e. Street and Number<br>7716 HANOVER PARKWAY #204   |  |   | 10f. Zip Code<br>20770                             |  | 10g. Citizen of What Country?<br>U.S.A.  |  |                                   |
|                                     | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |                                   |
|                                     | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>INTERPRETER FOR THE DEAF  |  | 16b. Kind of Business/Industry<br>HIGH SCHOOL  |  |  |                                   |
|                                     | 17. Father's Name (First, Middle, Last)<br>GEORGE SCHROEDER   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>NELLY VanHARTEN   |  |  |                                   |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br>GEORGE SCHROEDER  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>SAME AS ITEM #10  |  |  |                                   |
|                                     | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>CHAMBERS CREMATORY  |  | Date<br>7/8  | 20c. Location - City or Town, State<br>RIVERDALE, MD.  |  |                                   |
|                                     | 21. Signature of Funeral Service Licensee<br>W.W. Chambers  |  |   |  | 22. Name and Address of Facility<br>MOO091 W. W. CHAMBERS CO., RIVERDALE, MD. 20737  |  |  |                                   |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. KAPOSI SARCOMA<br>Due to (or as a consequence of):<br>b. Acquired Immune Deficiency Syndrome<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |                                   |
|                                     | Approximate Interval Between Onset and Death<br>8 months<br>4 years   |  |   |  |  |  |  |                                   |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                   |
|                                     |   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                   |
|                                     |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                   |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |                                   |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |                                   |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |                                   |
|                                     | 29b. Signature and title of certifier<br>Bruce Rashbaum M.D.  |  |   |  | 29c. License number<br>D32119  |  | 29d. Date signed (Month, Day, Year)<br>July 7, 1996  |                                   |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. BRUCE S. RASHBAUM M.D. 2311 M ST. N.W., SUITE 401, WASHINGTON, D.C.   |  |   |  |  |  |  |                                   |
|                                     | State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>JUL 09 1996                               |   | 32. Registrar's Signature<br>Juba Davidson-Randall |  |  |  |                                   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21989

## Certificate of Death

Reg. No.

|  |   |  |   |   |   |  |   |   |   |  |  |
|--|---|--|---|---|---|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Stephen Lee Sinden</b>   |  |   |   | 2. Date of Death<br>Month <b>July</b> Day <b>6</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>7:02 A.</b>                                      |   |   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Doctor's Community Hospital</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |  | 4c. County of Death<br><b>Prince George's</b>                           |   |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>164-30-1738</b>   |  | 6. Sex<br><b>XX</b> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 7, 1937</b>              |   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |
|  | Usual Residence of Decedent   |  |   |   |   |  |   |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |   | 10c. City, Town or Location<br><b>Greenbelt</b>   |  |   | 10d. Inside City Limits<br><b>XX</b> Yes <input type="checkbox"/> No        |   |  |  |
|  | 10e. Street and Number<br><b>35K Ridge Road</b>   |  |   |   | 10f. Zip Code<br><b>20770</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                   |   |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <b>XX</b> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <b>XX</b> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <b>XX</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+ 4</b>  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Research Scientist</b>  |   |  | 16b. Kind of Business/Industry<br><b>U.S.D.A.</b>                       |   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>James Whaples Sinden</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Cecile Marie Priest</b>   |  |   |   |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Martha Eleanor Sinden</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as #10</b>   |  |   |   |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <b>XX</b> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                 |   | Date<br><b>7/8/1996</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>      |   |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Donald V. Borgwardt</b>   |  |   |   | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Road Beltsville, Md. 20705</b>                                   |  |   |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Adenocarcinoma of the lung, stage IV</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |   |   |   |  |   |   | Approximate Interval Between Onset and Death<br><b>2 yrs. 11 mos.</b>   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <b>3</b> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |  |   |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <b>XX</b> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <b>XX</b> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <b>XX</b> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |   |  |  |
| 27. Manner of Death<br><b>XX</b> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <b>XX</b> No            |   | 28d. Describe how Injury occurred   |   |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |   |  |  |
| 29a. Certifier (Check only one)<br><b>XX</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |   |  |   |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Donald V. Borgwardt</b>  |   |  |   | 29c. License number<br><b>D14730</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>July 8, 1996</b>              |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>8926 Woodyard Road Suite 201 Clinton, MD 20735</b>  |   |  |   |   |   |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>  |   |  |   | 32. Registrar's Signature<br><b>Jake Davidson-Randall</b>   |   |  |   |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21990

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |   |   |  |  |
|--|--|---|--|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>MURIEL F. SEIXAS   |   |  |  | 2. Date of Death<br>Month: July Day: 5 Year: 1996     |   | 3. Time of Death<br>7:55 A.M.                       |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>Springbrook Adventist Nursing Home |   |  |  | 4b. City, Town, or Location of Death<br>Silver Spring |   | 4c. County of Death<br>Montgomery                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>086-03-1178   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>81 Yrs.             |   | 8. Date of Birth (Month, Day, Year)<br>Oct. 4, 1914 |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>New York   |   | 10a. State<br>Maryland   |  | 10b. County<br>Montgomery                             |   | 10c. City, Town or Location<br>Silver Spring        |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>1114 Dunoon Road   |   | 10f. Zip Code<br>20903  |   | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary                                |  | 16b. Kind of Business/Industry<br>Private  |   |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Fuhse   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Lilly Withal  |   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Gail Morgenweck / Daughter   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1114 Dunoon Road, Silver Spring, Maryland 20903   |   |   |   |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Crematory  |  | Date<br>7/7/96   |   | 20c. Location - City or Town, State<br>Brentwood, Maryland  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>Alan J. Donnell   |  |   |  | 22. Name and Address of Facility Hines-Rinaldi Funeral Home<br>11800 New Hampshire Avenue<br>Silver Spring, Maryland 20904   |   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Arteriosclerotic heart disease<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |   |   |   | Approximate Interval Between Onset and Death<br>unknown  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Aortic stenosis<br>Diabetes mellitus<br>emphysema  |  |   |  |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>Rajindra K. Sarin M.B.B.S.   |  | 29c. License number<br>D13548  |   | 29d. Date signed (Month, Day, Year)<br>7.5.96   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>RAJINDRA K. SARIN 9801 GEORGIA AVENUE SILVER SPRING MD 20902   |  |   |  |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 09 1996   |  | 32. Registrar's Signature<br>John Davidson-Randall  |  |  |   |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21991

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florencio Sandoval

2. Date of Death

Month Day Year  
June 29, 1996

3. Time of Death

9:00AM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Nursing Center

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

525-07-0280

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 26, 1915

9. Birthplace (State or Foreign Country)

New Mexico

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14120 Chesterfield Road

10f. Zip Code

20853

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No WWII  
If Yes, Give  
Year or Dates: Korean13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Civil Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Jesus Maria Sandoval

18. Mother's Name (First, Middle, Maiden Surname)

Candelaria Maria Silva

19e. Informant's Name/Relationship (Type, Print)

Evelyn P. Sandoval/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14120 Chesterfield Road, Rockville, Maryland 20853


20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Santa Fe National Cemetery  
July 5, 1996

20c. Location - City or Town, State

Santa Fe, New Mexico

21. Signature of Funeral Service Licensee

 M0034822. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 W. Montgomery Avenue,  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

2 weeks

b. Cerebrovascular Accident

Due to (or as a consequence of):

3 weeks

c. Cardiovascular Disease

Due to (or as a consequence of):

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Approximate  
interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D41931

29d. Date signed (Month, Day, Year)

July 1, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald J. Schumacher, M.D. 2309 Shorefield Road Silver Spring, MD 20902-1825

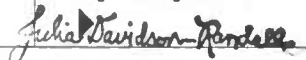
State

Registrar

31. Date filed (Month, Day, Year)

JUL 09 1996

32. Registrar's Signature



Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



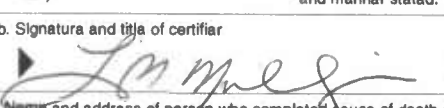
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

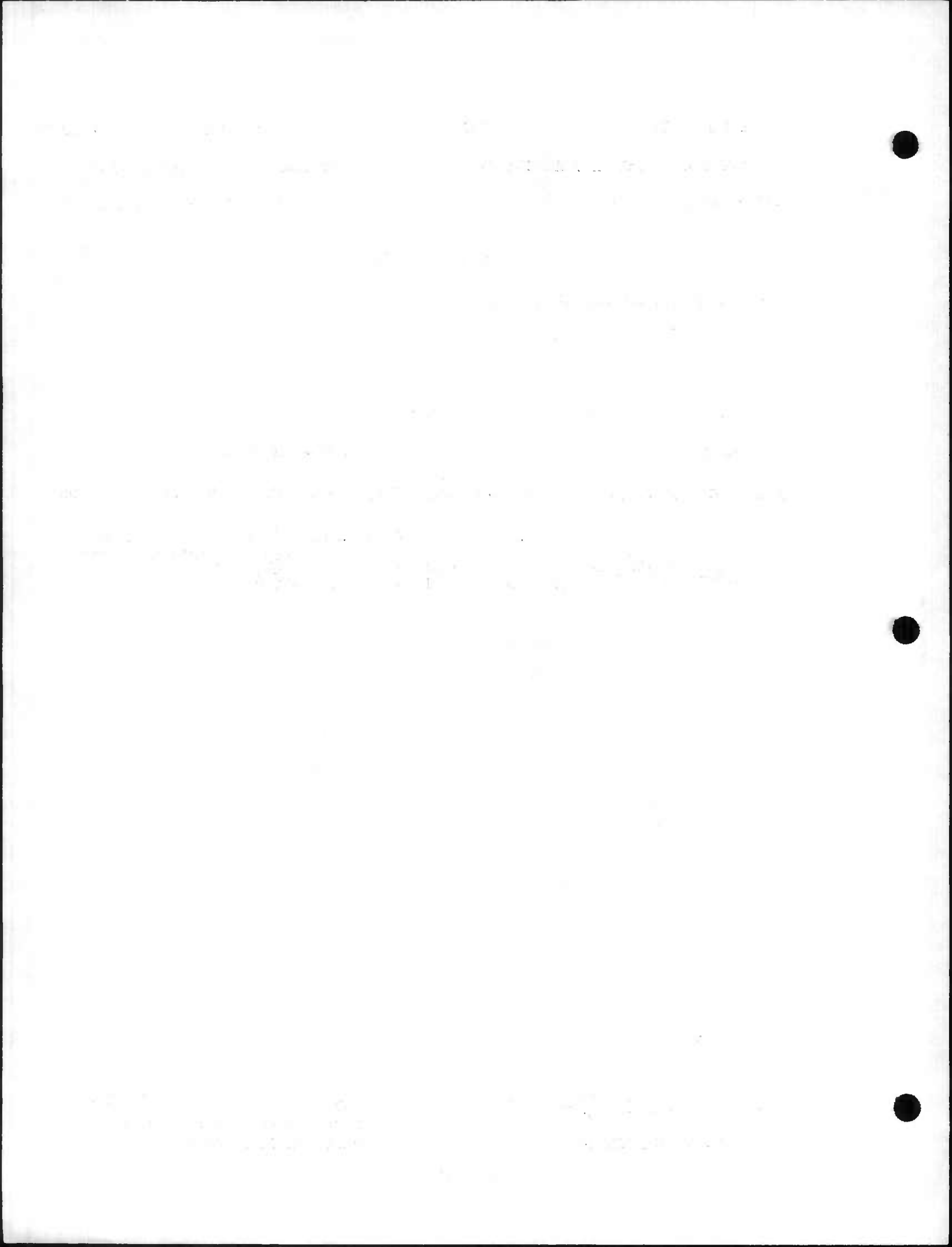
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21992

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MARTHA Totty SMITH</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 7 1996</b>   |  | 3. Time of Death<br><b>1:53 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>578-36-1950</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 2, 1921</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Centerville, TN</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Washington, D.C.</b>  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>4000 Cathedral Avenue, N.W. #708-B</b>  |  |   |  | 10f. Zip Code<br><b>20016</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Walker Totty</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Carothers</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Arthur C. Smith, Jr.-Husband</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>#708-B 4000 Cathedral Ave., N.W., Washington, D.C. 20016</b>                             |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cem.</b>  |  | 20c. Date<br><b>7/18/96</b>  |  | 20d. Location - City or Town, State<br><b>Arlington, VA</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, D.C. 20016</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. SUBARACHNOID HEMORRHAGE COMPLICATED BY</b><br>Due to (or as a consequence of):<br><b>b. RESPIRATORY ARREST</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |  |  |   |  |
|   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |  |
|   | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D-46475</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>07-08-96</b>  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>L. MULLIGAN, LT, MC, USN</b>  |  |   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JUL 12 1996</b>  |  |   |  | 32. Registrar's Signature<br>   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

96 21993

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH DUKE SCHOLLER

2. Date of Death

Month Day Year  
JULY 8, 1996

3. Time of Death

17:40

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Route 90 East

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

092-26-8645

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC 4, 1919

9. Birthplace (State or Foreign Country)

Hungary

Usual Residence of Decedent

10a. State

VA

10b. County

Fairfax

10c. City, Town or Location

ALEXANDRIA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5539 JANELLE ST

10f. Zip Code

22303

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Building  
Maintenance

17. Father's Name (First, Middle, Last)

Anthony Scholler

18. Mother's Name (First, Middle, Maiden Surname)

Ann Leptich

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Scholler/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5539 Janelle Street, Alexandria, Virginia 22303

20a. Method of Disposition


1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Mount Comfort  
Crematory

Date

7/12/96 Alexandria, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Demaine Funeral Homes, Inc.  
Alexandria, Virginia 2231423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) roadside

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury


M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D31473

29d. Date signed (Month, Day, Year)

JULY 8, 1996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

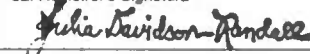
PATRICIA A. TATE, MD 4565 HENLOCK CONEWAY ELICOTT CITY MD 21042

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 1996

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

96 21994

Reg. No.

|                                     |  |  |   |  |   |  |  |  |   |  |   |  |
|-------------------------------------|--|--|---|--|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Jose S. Santos</u>  |  |   |  |   |  | 2. Date of Death<br>Month <u>July</u> Day <u>3</u> Year <u>1996</u>  |  | 3. Time of Death<br><u>4:PM</u>   |  |   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><u>Holy Cross Hospital</u>   |  |   |  |   |  | 4b. City, Town, or Location of Death<br><u>Silver Spring</u>   |  | 4c. County of Death<br><u>Montgomery</u>  |  |   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><u>217-15-5076</u>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>86</u> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><u>Jan. 25, 1910</u>  |  | 9. Birthplace (State or Foreign Country)<br><u>Chile</u>  |  |   |  |
|                                     | Usual Residence of Decedent  |  |   |  |   |  | 10e. State<br><u>Maryland</u>  |  | 10b. County<br><u>Montgomery</u>  |  | 10c. City, Town or Location<br><u>Rockville</u>   |  |
| To Be Completed by Funeral Director | 10e. Street and Number<br><u>13207 Parklawn Drive</u>  |  |   |  |   |  | 10f. Zip Code<br><u>20853</u>  |  | 10g. Citizen of What Country?<br><u>Chile</u>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <u>Chilean</u>   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Hispanic</u>   |  | 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u> |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Self-employed</u>                   |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br><u>College (1-4or 5+)</u>   |  | 16b. Kind of Business/Industry<br><u>Barber</u>   |  | 17. Father's Name (First, Middle, Last)<br><u>Unobtainable</u>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Unobtainable</u>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Rosa Santis / Wife</u>                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>11717 Leona Street, Wheaton, Maryland 20902</u> |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Gate of Heaven Cemetery</u>  |  | Date<br><u>7/11/96</u>  |  | 20c. Location - City or Town, State<br><u>Silver Spring, Maryland</u>  |  | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>                                       |  | 22. Name and Address of Facility<br><u>Hines-Rinald Funeral Home</u><br><u>11800 New Hampshire Avenue</u><br><u>Silver Spring, Maryland 20904</u>   |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>Pneumonia</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><u>Diabetes Mellitus</u><br><u>Cervical and lumbar disc with radiculopathy</u><br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><u>Diabetes Mellitus</u><br><u>Cervical and lumbar disc with radiculopathy</u> |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br><u>M</u>  |  | 28b. Time of Injury<br><u>1</u> Yes <input type="checkbox"/> No                                       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><u>Hugo G. Graziani MD</u>   |  | 29c. License number<br><u>DO 8188</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>7-4-96</u>   |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>HUGO G. GRAZIANI MD 717 PERSHING Drive SS MD 20910</u>  |  | 31. Date filed (Month, Day, Year)<br><u>JUL 12 1996</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21995

## Certificate of Death

Reg. No.

|  |  |  |   |                                |  |
|--|--|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Jeanne Finn Sweeterman   |  | 2. Date of Death<br>Month Day Year<br>July 10 1996  |                                | 3. Time of Death<br>3:15pm   |
|  | 4e. Facility Name (If not institution, give street and number)<br>Suburban Hospital  |  | 4b. City, Town, or Location of Death<br>Bethesda  |                                | 4c. County of Death<br>Montgomery  |
| Funeral<br>Director  | 5. Social Security Number<br>577-62-0792   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>84 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br>March 20, 1912  |  | 9. Birthplace (State or Foreign Country)<br>New York  |                                |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent  |  |   |                                |  |
|  | 10a. State<br>FL   | 10b. County<br>Palm Beach  | 10c. City, Town or Location<br>Delray Beach   |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  | 10e. Street and Number<br>936 Seaseage Drive   |  | 10f. Zip Code<br>33483  |                                | 10g. Citizen of What Country?<br>U. S. A.  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 2  |                                |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |  | 16b. Kind of Business/Industry<br>Own Home  |                                |  |
|  | 17. Father's Name (First, Middle, Last)<br>John D. Finn  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Laura Prenatt  |                                |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br>Carol Schiff - Daughter  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12 Stonybrook Road Westport, CT 06880  |                                |  |
|  | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Calvary Cemetery  |                                | 20c. Location - City or Town, State<br>Dayton, Ohio  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>Joseph Gawler's Sons, Inc.<br>5130 Wisconsin Avenue, N.W.<br>Washington, D.C. 20016   |                                |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>CARDIAC ARREST<br>Due to (or as a consequence of):<br>Probable myocardial infarction   |  |   |                                | Approximate Interval Between Onset and Death<br>LESS THAN 24 HRS   |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>Hypertension   |  |   |                                |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension   |  |   |                                |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28e. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br>M   |
|  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| State<br>Registrar   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |  |
|  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br>DC 16520   |                                | 29d. Date signed (Month, Day, Year)<br>7/11/96   |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Mary W. Zwirb, M.D. 3301 New Mexico Ave. N.W. Washington, D.C. 20016   |  |   |                                |  |
| 31. Date filed (Month, Day, Year)<br>JUL 12 1996                     |  | 32. Registrar's Signature<br>  |   |                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



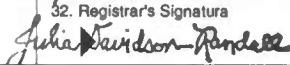
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21996

Amended #1, 7/9/96, MRT, Montg. Cty. Certificate of Death

Reg. No.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RAJ RANI SHARMA</b>                         |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>6</b> Year <b>96</b> |  | 3. Time of Death<br><b>17.25 PM</b>      |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b> |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>           |  | 4c. County of Death<br><b>Montgomery</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-06-6114</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.                  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.           |
|   | 8. Date of Birth (Month, Day, Year)<br><b>March 19, 1937</b>                               |   | 9. Birthplace (State or Foreign Country)<br><b>India</b>          |  |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Gaithersburg</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |
| 10e. Street and Number<br><b>17621 Lindstrom Court</b>  |  | 10f. Zip Code<br><b>20877</b>   |   | 10g. Citizen of What Country?<br><b>India</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:           |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian</b>   |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                               |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Nanak Chand Rishi</b>   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Sarswati Kalia</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sat Pal Sharma/Husband</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17621 Lindstrom Court, Gaithersburg, Maryland 20877</b> |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |   | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M00846</b>  |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>MULTIPLE TRAUMA</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |
| Approximate Interval Between Onset and Death<br><b>10 DAYS</b>  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>JUNE 26 1996</b>   |   | 28b. Time of Injury<br><b>10.30 PM</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>MOTOR VEHICLE ACCIDENT</b>  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>RT. 124 at MIDCOUNTRY HIGHWAY INTERSECTION</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>DOY099</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 7 96</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FRANCIS C MAYLE 1025 FERNWOOD RD BETHESDA MD 20817</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 09 1996</b>   |  | 32. Registrar's Signature<br>  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



8  
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96 21997

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |   |  |   |   |   |
|---|--|--|--|--|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EstHER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>7</b> DAY <b>7</b> YEAR <b>96</b>   |   |  |   | 3. TIME OF DEATH<br><b>4:55</b> P M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-28-8781</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3 29 09</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>         |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Bel Forest Nsg &amp; Rehabctr</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Forest Hill</b>  |   |  |   | 9c. COUNTY OF DEATH<br><b>HARFORD</b>   |   |
| 10a. STATE<br><b>PA</b>   |  |  | 10b. COUNTY<br><b>York</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Delta</b>   |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |   |
| 10e. STREET AND NUMBER<br><b>2524 Bryansville Road</b>  |  |  |  | 10f. ZIP CODE<br><b>17314</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nurse</b> |  |   | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Health</b>                                      |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Chester Wise</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eva Ruff</b>   |   |  |   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Richard Alban</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2524 Bryansville rd., Delta, PA 17314</b>  |   |  |   |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Bryansville Cemetery 7/10/96 Delta, PA</b>                 |  |  | 20c. LOCATION — City or Town, State   |  |   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE/LICENSEE<br><b>John D. Tallett</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Harkins F.H. Inc., Delta, PA 17314</b>  |   |  |   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebro Vascular Accident</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Postural Hypotension</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>old age Malnutrition</b> |  |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>3 years 5 yrs.</b>   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William MD</b>   |   | 29c. LICENSE NUMBER<br><b>D32609</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/7/96</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kamran Mulla, 703 Revolution St Haver De Grae MD 21078</b>  |  |  |  |  |   |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 9 1996</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Sharon K. R. R.</b>  |   |  |   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

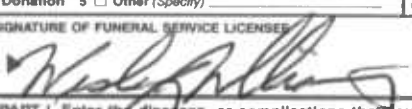

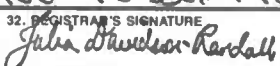




96 21998

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Richard Edward Slavin</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 13 1996</b>   |  | 3. TIME OF DEATH<br><b>7:30 PM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>217-32-1226</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>84</b>   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>August 14, 1911</b>                                |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Center</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LaPlata</b>   |  | 9c. COUNTY OF DEATH<br><b>Charles</b>   |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Charles</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Indian Head</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>108 Mattingly Ave.</b>   |  |   |  | 10f. ZIP CODE<br><b>20640</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Store</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self Employed</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Edward Slavin, Sr.</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence Marie Michaud</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Richard Edward Slavin, III</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>310W 55th st., #3J, New York, New York 10019</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Old Durham Episcopal Church</b>   |  | 20c. LOCATION — City or Town, State<br><b>Ironsides, Maryland</b>   |  | 20d. DATE<br><b>July 18, 1996</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><br><b>M00668</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Williams Funeral Home, P.A.<br/>Indian Head, Maryland</b>  |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Subdural hematoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiomyopathy (ischemic)</b>  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>B. L. Jenkins</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D33426</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/15/96</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 LaPlata Ave PO Box 1724 LaPlata Maryland 20640</b>  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 15 1996</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><br><b>John Davidson Randall</b>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

96 21999

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MILDRED LARUE SITTIG</b>  |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>9</b> Year <b>1996</b>   |  | 3. Time of Death<br><b>8:35 AM</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Carroll Lutheran Village</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>  |  | 4c. County of Death<br><b>Carroll</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-38-4185</b>  |  | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  |  | If Under 1 Year<br>Months Days<br>If Under 24 Hrs.<br>Hours Min.                               |  |
|   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Westminster</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>102 Timber Ridge Drive</b>  |  |   |  | 10f. Zip Code<br><b>21157</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b>   |  | Collage (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Domestic</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Vernon Mathias</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Schaeffer</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>William C. Sittig</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5549 Hollins Lane, Burke, Va 22015</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>John Luther Miller Memorial Cemetery, Westminster, MD</b>            |  | Data<br><b>7/11</b>   |  | 20c. Location - City or Town, State  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Robert A. Myers</b>  |  |   |  | 22. Name and Address of Facility<br><b>Myers Funeral Home<br/>91 Willis Street, Westminster, MD 21157</b>   |  |  |  |
|   | 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ASCVD</b><br>Due to (or as a consequence of):<br>a. _____<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____  |  |   |  |   |  |  |  |
|   | 23f. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>C.H.F., I.D.D.M., P.V.D., Hypothyroidism</b>   |  |   |  |   |  |  |  |
|   | 23g. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Hypothyroidism</b>   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 5. Pending investigation  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br><b>James L. Forsberg</b>   |  |  |  |
|   | 29c. License number<br><b>D33561</b>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>7-10-96</b>   |  |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James L. Forsberg 912 Washington Road, Westminster, MD 21157</b>  |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JUL 10 1996</b>  |  |   |  | 32. Registrar's Signature<br><b>John Andrew Rickett</b>   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Arthur Taylor  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 2, 1996  |  | 3. TIME OF DEATH<br>10:05 a. M   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-18-8882   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 5. AGE (In yrs. last birthday)<br>72 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>May 11, 1924  |  |
| 6. BIRTHPLACE (State or Foreign Country)<br>Crisfield MD   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Edw. W. McCready Memorial Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Crisfield  |  | 9c. COUNTY OF DEATH<br>Somerset  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Wicomico  |  | 10c. CITY, TOWN OR LOCATION<br>Marion   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>Post Office Box 14   |  |  |  | 10f. ZIP CODE<br>21838  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Laborer  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Farming   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Cornelius Taylor  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Justice   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ella Taylor  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 14, Marion, Maryland 21838  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Liberia Church Cemetery   |  | DATE<br>7/6/96  |  | 20c. LOCATION — City or Town, State<br>Marion, Maryland 21838  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bennie Smith Funeral Home<br>4th St. Pocomoke City MD 21851   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. DUE TO (OR AS A CONSEQUENCE OF):<br>Acute Myocardial Infarction<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>Cerebrovascular Accident<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>Hypertension<br>d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypercholesterolemia   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>William Gill MD   |  |  |  | 29c. LICENSE NUMBER<br>D15715   |  | 29d. DATE SIGNED (Month, Day, Year)<br>7.3.96  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>WILLIAM GILL MD BURTON AVE. CRISFIELD 21817   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 12 1996   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Pendall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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